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The Substance Abuse Treatment Experience of Men Who Have Sex with Men

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The Substance Abuse Treatment Experience of Men Who Have Sex with Men

by

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the requirements for the degree of
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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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Doctor of Philosophy, Graduate Program in Marital and Family Therapy
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Dr. Curtis Fox, Co-Chairperson and Dr. Douglas Huenergardt, Co-Chairperson

The following qualitative research study focuses on the substance abuse treatment experiences of men who have sex with men. Current research in this area indicates that while these men sometimes seek treatment for substance abuse issues, their treatment experience can be compromised due to personal fears or ignorance on the part of treatment staff members or others in treatment (Cabaj, 2008; Cheng, 2003; Hellman, Stanton, lee, Tytun, & Vachon, 1989). Specific goals of this study include: (1) gaining insight into the treatment experience(s) of these men and (2) learning about how their individual and collective treatment experience(s) contribute to their ability to remain abstinent after completing treatment. Symbolic interactionism is the theoretical framework that undergirds this study. The research design incorporates an in-depth analysis of case notes and observations from a sample comprised of 24 men. In addition, "member checks" (Guba, 1981; Lincoln & Guba, 1985; Moustakas, 1994), or follow-up interviews, were conducted with a small subset of this sample to gain further insight into their individual treatment experiences. This study has implications for practice as marriage and family therapists, substance abuse counselors, and others who work with men in substance abuse treatment programs, as well as for researchers who work with this population.

CHAPTER ONE

INTRODUCTION

From June of 2008 until May of 2014, it was the opportunity of the researcher to work for a non-profit organization that offers a variety of mental health and substance abuse treatment services to the community in Riverside County, California. While working there as a marriage and family therapist trainee and intern, I worked with individuals, couples, children, and families in therapy. During this same time period, from 2008 to 2011, I was also asked to work in the organization's residential substance abuse treatment facility for men, offering them individual and couples therapy services. While working in this capacity, I had the opportunity to work with men struggling with addiction from widely varied backgrounds. These men came to treatment from various socioeconomic and social backgrounds, represented numerous ethnic and religious groups, and had achieved differing levels of personal, professional, and academic success. Many of those with whom I worked came directly to treatment from the California State Prison system or from living on the streets. At the time of treatment, some of these men reported having been involved in criminal activities or reported being former gang members. Additionally, these men reported being or having been married, some reported having children, and still others reported being single at the time of treatment. Although these men were all very different, they also shared some things in common. First, all of them struggled in some way with substance abuse and with substance abuse-related issues. Second, in the privacy of the therapy room, some of these men identified as gay or bisexual and/or reported having had sexual experiences with other men.

In individual therapy, many of these men report that they do not reveal their gay identities or their same-sex attraction or experiences to others while in treatment due to feelings of fear. They fear being judged, mistreated, or even being physically or sexually assaulted by those who do not accept or understand them. Their concerns pertain to both fellow clients and to treatment staff members. After hearing and processing the collective treatment experience and concerns of these clients, I began to wonder about what could be done to improve the quality of their substance abuse treatment experience. In addition, I became increasingly aware of how being unable to disclose their sexual experiences or sexual orientation while participating in process groups could have an adverse effect on their overall treatment experience. Some of these men even report that not having the freedom or the courage to disclose their sexual feelings or identity while in treatment contributed to less successful treatment outcomes or to relapse.

Objective

The objective of this study was two-fold. First, from the position of an observant participant (Bolton, 1995; Kaminski, 2004) in the treatment setting, I wanted to better understand what it was like for these men to come to a substance abuse treatment program in which they did not feel free to disclose their sexual orientation, sexual experiences, or their sexual feelings. Second, I was very interested to learn about how their inability to be completely open about these things while in treatment impacted the quality of their treatment experience and their ability to remain abstinent from drugs and alcohol after treatment. Thus, the overall research question for this study was: What is the experience of men who have sex with men (MSM) in substance abuse treatment and

recovery? Sub-questions included: a) How does withholding important information about one's sexual identity impact the quality of their substance abuse treatment experience? b) How does disclosure of one's sexual activities and sexual experiences while in treatment affect treatment experience? c) How may disclosing or choosing not to disclose one's sexual activities or sexual preferences while in treatment influence ability to remain abstinent from drugs and alcohol after treatment?

Rationale

Substance abuse does not discriminate on the basis of gender, age, ethnic background, socioeconomic status, religious affiliation, or sexual orientation. However, studies show that it impacts the members of each of these categories in very different ways (Connors, Donovan, & DiClemente, 2001; Halktis & Jerome, 2008; Rowe & Liddle, 2002; SAMHSA, 2014; Stanton & Todd, 1982). In recent years, researchers have discovered that men who have sex with men (MSM) have a higher rate of substance abuse in comparison to that of the general population (Cabaj, 2008; Cheng, 2003; Flentje, Heck, & Sorensen, 2015; Lopez-Patton, Kumar, Jones, Fonseca, Kumar, & Nemeroff, 2016). In spite of this reality, comparatively few of these men seek treatment for their substance abuse issues (SAMSHA, 2014; Bakker, Sandfort, VanWessenbeeck, & Westert, 2006; Mackesy-Amiti, Fendrich, & Johnson, 2009). Out of those that do, very few reveal their sexual preference(s) during treatment, fearing judgment, harassment, or even a violent response from their counselors or fellow clients (Hellman, Stanton, Lee, Tytun, & Vachon, 1989; Logan & Barret, 2006). In addition to the possible interference that these personal concerns pose to successful treatment outcomes for these men,

another important factor merits examination. That factor involves the limitations of treatment staff training. Eldridge and Barnett (1991) note that substance abuse counselors are usually well-trained to deal with clients' substance abuse issues, but may not have received instruction on how to address issues pertaining to sexual orientation.

With all that is known about substance abuse, there is no easy explanation for why some people develop substance abuse issues while others do not (Mendelson & Mello, 1985; Rathbone-McCuan & Stokke, 1997; SAMSHA, 2014; SAMSHA, 2013). However, a review of the environmental and psychosocial stressors impacting gay men in general, gives rise to several explanations for the high rate of substance abuse within the gay community. Some of these are homophobia, the coming out process, and the effects of HIV/AIDS.

Homophobia

Weinberg (1972) defines homophobia as an irrational fear of any and all people and things related to gay men. Herek (1996) describes two different types of homophobia that impact gay men relationally. Externalized homophobia is generated by the heterosexual community or by anyone who dislikes or fears homosexuals. Internalized homophobia is generated from within the gay individual. From a very early age, gay men internalize society's ideology of sex and gender roles. When they become aware that their sexual feelings are at odds with these heterosexist norms, they often feel a sense of shame and sadness. Research identifies homophobia as one of the most insidious and pervasive factors impacting the gay population (Baker, 2002; Hilton, 1992; Russell & Fish, 2016; Warn, 1997). Warn asserts that homophobia directly contributes to

the substance abuse issues of gay men because the use of alcohol and other drugs masks the tension between them and their environment. Hardin (1999) and Weinberg (1994) suggest that gay men resort to substance abuse to reduce the negative feelings they experience in relationship to their own internalized homophobia.

The Coming Out Process

Herek (1996) states that individuals that ultimately identify as gay, go through a life process during which they become aware of their sexual feelings and gradually develop a gay identity. Some of these individuals choose to disclose their sexual identity to others. This process of disclosure is what is termed as coming out of the closet. Benshoff and Janikowski (2000) suggest that many gay individuals are anxious about coming out, fearing rejection or hostility from their friends, families, or from society. They also observe that for many of these individuals, these very fears and anxieties are realized in devastating life experiences. After coming out to others, gay individuals are often condemned by others for their sexual preferences and sexual practices (Hardin, 1999; Hogan & Hudson, 1998; Kantor, 1998; Russell & Fish, 2016). Cheng (2003) suggests that unless they are equipped with a "well-developed repertoire of coping mechanisms" (p. 336), they may be more inclined to turn to alcohol and drugs to relieve their emotional pain.

The Effects of HIV and AIDS

Acquired Immunodeficiency Syndrome (AIDS) has had a very profound effect on almost every aspect of gay life since the first case was diagnosed in the early 1980's

(Cabaj, 2008; Cheng, 2003; Bonell, Weatherburn, Rhodes, Hickson, Keogh, & Elford, 2008; Phillips, Magnus, Kuo, Rawls, Peterson, West-Ojo, Jia, Opoku, & Greenberg, 2014). Medical studies indicate that AIDS develops in the body after an individual has been infected by the human immunodeficiency virus or HIV (Hogan & Hudson, 1998). In light of the fact that HIV is often spread through sexual contact, gay men have a higher chance of contracting the virus in connection with having multiple sex partners. Although recent advances in HIV/AIDS research and treatment now allow those infected with the disease to live longer and more productive lives, becoming aware that one is or has been infected with HIV can be devastating. Some research suggests that gay men turn to substance abuse to cope with the stress and pain associated with being diagnosed with HIV or to cope with the loss of a friend or lover to the disease (Bensoff & Janikowski, 2000; Ratner, 1993).

From the research highlighted here, it is clear that men who have sex with men (MSM) have a larger predisposition to incur substance abuse problems because of the unique challenges they face (Cabaj, 2008; Cheng, 2003; Flentje, Heck, & Sorenson, 2016; Lopez-Patton et al., 2015). However, this same body of research indicates that MSM seldom seek treatment for their substance abuse issues for various reasons including fear, rejection, and the threat of violence (Bakker, Sandfort, VanWessenbeeck, & Westert, 2006; Logan & Barret, 2006; Mackesy-Amiti, Fendrich, & Johnson, 2009). In addition, this same body of research illuminates several factors that, taken together, provide critical insight into those substance abuse issues that impact gay men specifically (Baker, 2002; Benshoff & Janikowski, 2000; Cheng, 2003; Hilton, 1992; Warn, 1997). Therefore, this research study is much needed to better understand the substance abuse

treatment experiences of men who have sex with men so that marriage and family therapists, substance abuse counselors, clinicians, and treatment staff members can offer them the most impactful treatment possible. Additionally, this study also provides critical insight regarding specific factors that contribute to or detract from successful post-treatment outcomes for this clinical population.

CHAPTER TWO

CONCEPTUAL FRAMEWORK

The examination of factors that contribute to the experience of men who have sex with men in substance abuse treatment was explored through the lens of symbolic interactionism. Because symbolic interaction theory concerns itself with the understanding and development of the self and the use of symbols and social interaction in the creation of identity and meaning, it served as an effective and helpful guide in illuminating the thought processes and lived experiences of the men that make up the sample of this study. In addition, because of its unique position in the history of family studies and its eclectic theoretical composition, symbolic interaction theory can easily be used in various quantitative and qualitative research designs, making it a logical choice for this study (LaRossa, 1988; LaRossa & Wolf, 1985).

Because symbolic interactionism is concerned with how humans create symbolic worlds, both individually and collectively, and with how these worlds are then used to shape human thought and behavior (Fisher & Strauss, 1978; LaRossa & Reitzes, 1993), it was an effective tool for providing insight into the processes that take place in the study subjects' lives that help or hinder them in the development of self, various roles and identities, and in the creation of meaning. For some of the men comprising this study's sample, failed attempts at developing a desired masculine identity, perceived or real rejection from self or others, or the individual or collective assignment of negative meaning to certain identities, roles, interactions, and contexts, lead them to substance abuse in a desire to cope and, sometimes, subsequently to a desire to seek substance abuse treatment (Baker, 2002; Cabaj, 2008; Cheng, 2003; Hardin, 1999).

Introduction

Symbolic interactionism stands out as one of the most unique and important theoretical orientations in family studies today (LaRossa & Reitzes, 1993). As the principal family theory of 1920s and 1930s, it emerged as the field of family studies was still establishing itself as a science. As such, it is revered by many as having impacted the study of the family more than any other theoretical perspective (LaRossa & Reitzes, 1993). Symbolic interactionism holds a place of honor in the field of family studies due to two primary factors: a strong conceptual heritage that continues to attract the minds of inquisitive students and scholars alike, and a strong tradition of research, being one of few theoretical perspectives that has consistently relied on both qualitative and quantitative research methods in its development and application (LaRossa & Reitzes, 1993).

As the name suggests, the main focus of symbolic interactionism is the connection existing between symbols (i.e., shared meanings) and interactions (i.e., verbal and nonverbal communications and actions) (La Rossa & Reitzes, 1993; Ritzer & Goodman, 2004a). At its very essence, symbolic interactionism is a frame through which one can understand how humans create symbolic worlds, both individually and collectively, and how these worlds shape human thought and behavior (Fisher & Strauss, 1978; LaRossa & Reitzes, 1993). Symbolic interactionists attribute causal significance to social interaction; symbols are created and acquire meaning through social exchanges with others instead of simply being created, attached to, or defined with language and mental processes alone (Ritzer & Goodman, 2004a).

Symbolic interactionism's contribution to the field of family studies is unique because of two important foundational concepts. First, symbolic interactionists emphasize the proposition that families are social groups, not just biological ones. Second, these theorists support the assertion that individuals and family members develop both a concept of self and their identities through social interaction, enabling them to independently assess and assign value to independent and family activities (LaRossa & Reitzes, 1993). The process of conceptualizing families as social units and as groups of interacting selves and identities has inspired symbolic interactionist-minded family researchers to ponder just how family members arrive at a more or less shared sense of the world (i.e., a symbolic reality—shared set(s) of goals, values, beliefs, and norms) while simultaneously developing, maintaining, and remaining individual selves (LaRossa & Reitzes, 1993; Ritzer & Goodman, 2004a).

History

Symbolic interactionism is a sociological perspective on the development of self and society, born out the early pragmatists' movement of the 19th century. Unlike other theoretical perspectives that are easy to identify with a single founder's name (i.e., Sigmund Freud: psychoanalytic perspective), symbolic interactionism is associated with several important names (LaRossa & Reitzes, 1993). It is largely based on the ideas of a group of well-known theorists closely associated with the University of Chicago in the early twentieth century including George Herbert Mead (Mead, 1934; Miller, 1973; Ritzer & Goodman, 2004a), Herbert Blumer (Blumer, 1966; Blumer, 1969; LaRossa & Reitzes, 1993), Charles Horton Cooley (Cooley, 1902/1956a; Ritzer & Goodman, 2004a),

Manfred Kuhn (Hickman & Kuhn, 1956; Kuhn, 1964), and William Isaac Thomas (Thomas & Znaniecki,1918-1920; LaRossa & Reitzes, 1993). To these early founders and theorists, symbolic interactionism offered a new, more scientific, view of the family unit and societal constructs than had previously been available (LaRossa & Reitzes, 1993; Ritzer & Goodman, 2004; Ritzer & Goodman, 2004a).

Instead of a single orthodox symbolic interaction theory, a number of variations of the theory developed in the 1950s and 1960s (LaRossa & Reitzes, 1993; Ritzer & Goodman, 2004a). Over time, two major variates of the theory emerged and became known as the two "schools" of symbolic interactionism (Meltzer & Petras; 1972). The "Chicago School," headed by Herbert Blumer (1900-1987), the originator of the term "symbolic interactionism," and the "Iowa School" headed by Manfred Kuhn (1911-1963) (LaRossa & Reitzes, 1993; Ritzer & Goodman, 2004). There were three major differences between the two schools. The first difference was a methodological one. Blumer emphasized what he referred to as the "interpretive" process in the social construction of meaning, which endorsed the use of qualitative methods such as autobiographies, case studies, life histories, participant observation, and interviews (Blumer, 1969, p. 41). Conversely, Kuhn (1964) wanted to test the premises of symbolic interaction theory and called for studies to construct testable hypotheses of symbolic interactionist propositions, using operational definitions and variables leading to quantitative data gathering and empirical data analysis.

The second difference between the two symbolic interactionist schools was how each viewed human behavior. Drawing heavily on Mead's concepts of "I" and "Me," Blumer (1962) recognized that that human behavior was inherently unpredictable, and,

therefore, offered a distinct source of innovation and variation in societal development. Kuhn's view of the self concentrated on Mead's concept of "Me," and investigated the impact of attitudes about the self on individual behavior, using a form of role theory (Meltzer & Petras, 1972, p. 50). The third difference involved how each school defined the self and society. Blumer (1966) asserted that social arrangements were continuously negotiated because the character of self and society was dynamic, fluid, and processual. In stark contrast, Kuhn (Hickman & Kuhn, 1956) viewed the self as a stable construct of fixed attitudes derived from social roles and the interaction of those roles.

The Chicago-Iowa controversy ought not to be ignored in the history of family studies because of the influence this division has had on the development of the field itself (LaRossa & Reitzes, 1993). In recent years, the Iowa School appears to have more influence on family researchers, while the Chicago School, including its emphasis on process and fluidity, seems to have impacted symbolic interactionists in social psychology and those in other areas of study (Hutter, 1985). LaRossa (1988) and LaRossa and Wolf (1985) state that one implication of the absence of a strong Chicago School orientation is the relative weight that family scholars give to qualitative versus quantitative research. They assert that because it was the Chicago School that provided a lattice work for conducting qualitative research, the absence of a strong Chicago School orientation in family studies is one possible explanation for the infrequent use of qualitative study methods in the field.

Themes and Assumptions

Symbolic interactionism evolved out of the early pragmatist tradition in early twentieth-century America. As such, it brought with it a uniquely American enthusiasm to working out new "scientific" ways to systemically study human behavior. The combination of an emergent new discipline, a new century, and the evolution of a new urban industrial society, provided the fertile soil in which the core assumptions of symbolic interactionist theory were sewn (LaRossa & Reitzes, 1993; Ritzer & Goodman, 2004). The foundation of symbolic interactionism is built on seven assumptions that fall naturally into three central themes.

First Theme

The first central theme of symbolic interactionism concerns itself with the meaning(s) associated with human behavior. LaRossa and Reitzes (1993) use Herbert Blumer's (1969, pp. 2-5) three premises as a way of organizing the first three assumptions associated with this theme.

First Assumption

"Human beings act toward things on the basis of the meanings that the things have for them" (LaRossa & Reitzes, 1993, p. 143). Blumer (1969) asserts that because symbolic interactionism embraces a non-reductionistic view of human beings, there exists a "loop" of conscious thought and the cognitive meaning(s) between feelings and actions and/or between stimulus and response. This assumption separates symbolic interactionism from other schools of thought, such as psychological behaviorism, that

interpret human behavior in terms of observable objects that serve as the direct, non-reflexive stimulus for a response (LaRossa & Reitzes, 1993).

Second Assumption

"Meaning arises in the process of interaction between people" (LaRossa & Reitzes, 1993, p. 143). Symbolic interactionists highlight the importance of cognitive processes and meaningful action in human behavior. However, they differ somewhat in their understanding of where meaning originates. Mead (1934) proposes that meaning is intersubjective and rests in symbols. In this way, he defines symbols as shared interpretations that produce a common response, both in the individual, and in others.

Third Assumption

"Meanings are handled in and modified through an interpretive process used by the person in dealing with things he or she encounters" (LaRossa & Reitzes, 1993, p. 143). This third assumption serves as an extension of the second, suggesting that individual meanings not only become real through interaction with others, but that this interaction also shapes the individual's reality. In this way, individuals respond to and interpret reality through the symbols they share in their environment. This assumption also suggests that individuals utilize shared symbols to assign specific meaning(s) to self, others, and social settings (Blumer, 1969).

Second Theme

The second central theme of symbolic interactionism focuses on the concept and

development of the self. Symbolic interactionists maintain a nondeterministic view of human behavior. Their position is based on the assertion that an individual develops a social and active self through social interaction and that this self-concept later becomes an integral motive for human behavior (LaRossa & Reitzes, 1993).

Fourth Assumption

"Individuals are not born with a sense of self but develop self concepts through social interaction" (LaRossa & Reitzes, 1993, p. 144). Cooley (1902/1956a) developed this insight with his concept of the "looking glass self." He believed that children develop a sense of "my" and "mine" and begin to contextualize a concept of "we" and "others" through social interaction. Burgess (1926) and Waller (1938) asserted that the family unit was the setting in which humans learn norms and values, including conflicting expectations and tension between the ideals of self and society maintained by parents and their children.

Fifth Assumption

"Self concepts, once developed, provide an important motive for behavior" (LaRossa & Reitzes, 1993, p. 144). An important tenet of symbolic interactionism is that human behavior is influenced by self-beliefs, positive self-assessments, self-feelings, and the formulation of self-values. Mead (1934) developed what he called self-initiated behavior in two ways. First, he proposed that once an individual is able to view himself/herself from the perspective of the generalized other, he or she is also able to use this same perspective to independently assess the responses of selected others. Second,

he maintained that the concept of "I," or the acting self that operates in the immediate present, lends itself to the idea that behavior can never be completely determined because possible actions/responses are infinite.

Third Theme

The third central theme of symbolic interactionism is related to symbolic interactionist assumptions about society. In various forms, the pioneers of symbolic interactionism focused on what they coined as "social process" and on the relationship between individual and collective freedom(s) and "societal restraint" (LaRossa & Reitzes, 1993, p. 144).

Sixth Assumption

"Individuals and small groups are influenced by larger cultural and societal processes" (LaRossa & Reitzes, 1993, p. 144). Proponents of symbolic interactionism are aware that societal norms and values influence individual and collective behavior. In addition, symbolic interactionism has evolved with an awareness that certain evolutionary factors and changes in social mores and expectations can contribute to family disorganization and changes in family structure in urban society (Hutter, 1985, p. 125). Burgess (1926) recognized these mores and 'folkways' heavily influence the ways in which families interact and acknowledged that rapid social change may lead to family discord and family conflict.

Seventh Assumption

"It is through social interaction in everyday situations that individuals work out the details of social structure" (LaRossa & Reitzes, 1993, p. 144). Symbolic interactionists have consistently disagreed with the notion that static social structure determines behavior. Rather, they emphasize the fluid, dynamic character of social structure. This position is couched in the assertion that outcome(s) of social situations cannot be solely determined by objective variables; they are also heavily influenced by the subjective attitudes and the situational definitions held by the interacting individuals/groups (LaRossa & Reitzes, 1993).

Concepts and Applications

With their monumental work, *The Polish Peasant in Europe and America*, Thomas and Znaniecki (1918-1920) established a legacy of research that continues to influence how symbolic interactionists approach the study of family life and social life to this day (LaRossa & Reitzes, 1993). Within this rich legacy, there have been many thought-provoking and interesting theories which, when taken in aggregate, have given rise to four sets of concepts that form the center of current symbolic interactionist theory and research. Although these concepts can be separated analytically, in reality all four of them are interrelated. Beginning at the microlevel and moving toward the macrolevel, the four sets are: (1) identities, (2) roles, (3) interactions, and (4) contexts (LaRossa & Reitzes, 1993).

Identities

In symbolic interactionist theory, the term "identities" refers to self-meaning in a role. In other words, individuals construct their identities according to how they define a particular role they are assuming. Generally, identities are organized hierarchically according to their "salience." McCall and Simmons (1978) suggest that the salience of a particular identity will determine how motivated an individual will be in performing and/or exceling in role-related behaviors. Research demonstrates that the salience of a given identity is influenced by an individual's commitments. In this context, the term "commitment" refers to the cost of giving up a social relationship, a type of behavior or action, or an identity (Burke & Reitzes, 1991; Stryker, 1968).

The most frequently studied aspect of identity in symbolic interactionism is "self-esteem," which typically includes how one evaluates one's self (Wylie, 1979). Symbolic interactionists assert that the desire to have and maintain a positive self-esteem becomes a powerful motive for behavior, and that behavior becomes an influential determinant of self-esteem (Rosenberg, 1979). Gecas (1982, p. 22) discovered that self-esteem impacts conformity, educational achievement, moral behavior, interpersonal attraction, along with various aspects of mental health and personality. The work of Kaplan and Pokorny (1969) demonstrated that poor conceptions of self, or "self-derogation," were connected to depressive affect, physical indicators of anxiety, and to the frequent use of psychiatric services/assistance. Lastly, the research of Luck and Heiss (1972) found that self-esteem was related to autonomic and psychic anxiety, submissiveness, depression, and higher levels of maladjustment and vulnerability among adult White males.

Roles

Heiss (1981) defines roles as shared norms applied to the occupants of social positions. For symbolic interactionist theorists, roles are systems of meaning that allow role occupants and those with whom they interact to both anticipate future behavior and maintain some form of predictability in their social interactions (Turner, 1970). Generally speaking, roles can only be understood in relationship to counter or complementary roles (Lindesmith & Strauss, 1956). The roles of mother and father simultaneously emerge and take on meaning in relationship to one another, and parental roles invite comparison and contrast when they are compared to the role(s) of children (LaRossa & Reitzes, 1993).

Roles may vary across social position. Formal roles such as mother, brother, employer, or employee refer to positions within social groups, organizations, or institutions. Conversely, informal roles such as lover or best friend, occupy an interpersonal or interactional position, that while recognized by self and other, may not be recognized or understood by others. Just how formal and informal roles are determined is negotiable, but there is more room for the negotiation of informal roles. Roles are malleable and have flexible boundaries that allow individuals to construct different identities in a role, e.g., the role of spouse may contain the identities of economic provider, sexual partner, and confidant (LaRossa & Reitzes, 1993).

From a symbolic interactionist perspective, this process of creating and assuming roles is critical to the socialization process. This is the process in which concepts of self and identity—inexorably tied to role performance—are developed and regulated. Thus, to social interactionists, a child is seen as being socialized rather than simply taught to

conform to social cues and expectations. Child socialization is understood to be a complex process in which children do not just memorize roles, but actively participate in the formation of their own identities through learning and assuming various roles (LaRossa & Reitzes, 1993; Rosenberg, 1979).

Interactions

According to symbolic interaction theory, the presentation of self in everyday life requires the use of verbal and nonverbal cues and symbols to communicate and announce one's role and identity. It is through the use and application of these cues and symbols that individuals create meaning(s) attached to self, others, and social situations (LaRossa & Reitzes, 1993). At times, because individuals are simultaneously aware that others are assessing their self-presentations, efforts are made at impression management. Impression management operates on several levels of reflexivity. Dating and courtship is an effective illustration of this concept because it involves two "actors" striving to create positive impressions while simultaneously being aware that at least some part of their partner's "performance" could be "staged" (Turner, 1970, pp. 18-37). There is also an underlying moral character assigned to the presentation of self. Once an individual has presented a specific role or identity, he or she is expected to live in a way that merits that identity's position and others are expected to respect it (Goffman, 1978, p. 176). One of our courting "actors" could feel cheated if their partner gave the impression that they were going to do housework prior to marriage, but refused to cook or clean afterward (LaRossa & Reitzes, 1993).

As stated above, in addition to the meaning(s) attributed to self and others,

meaning is also given to different situations. Situations may be defined in any number of ways (e.g., fair or unfair, safe or unsafe) and it is assumed that individual and group behavior will be influenced by how they are defined. Symbolic interactionists assert that the processes involved in the development of somewhat shared situational definitions are crucial to any group or societal success. They note that complete agreement on such definitions is rarely achieved and that social life, therefore, almost always proceeds with what can be termed as a "working consensus" (LaRossa & Reitzes, 1993). Goffman (1978, p. 175) asserts that it is the achievement of such a working consensus that provides social situations with a form of regularity and predictability.

As members of a group or society are working together to create and maintain a working consensus, they will naturally monitor whether things are "normal" or not. If it appears that an individual is guilty of violating some aspect of the group's culture, he or she will be expected to "account" for his or her infraction. An account is defined as a "statement made by a social actor to explain unanticipated or untoward behavior." The statement may take the form of an excuse, where the individual admits to wrongful behavior but denies responsibility, or justification, accepting responsibility but denying that they did anything wrong (Scott & Lyman, 1968, pp. 46, 47). Every account is viewed as a part of the underlying processes of identity negotiation and development (LaRossa & Reitzes, 1993).

Contexts

Understanding the connection existing between the individual and society has long been an area of interest to symbolic interactionists. A central theme in symbolic

interaction theory is the concept of aligning actions, which is based in the idea that human behavior is shaped by culture and culture is shaped by human behavior (Stokes & Hewitt, 1976). Historically, theorists who study the impact of culture on behavior generally give too much to a programmed routine. Conversely, theorists who study the impact of human behavior on the greater culture generally overestimate the capacity of individuals and groups to create order and meaning, asserting that societal chaos in a world that is too fluid and changeable can only be avoided through constant monitoring (Stokes &Hewitt, 1976).

The negotiated order approach to social organization is probably the most explicitly articulated attempt in contemporary symbolic interactionism to define and describe the connection between the individual and society (Strauss, 1978). Three main concepts comprise the foundation of this approach: negotiation, negotiation context, and structural context. *Negotiation* refers to the many ways of "getting things accomplished" and includes compromising, bargaining, and participating in collusion. *Negotiation context* refers to the structural properties and elements that immediately and inevitably impact negotiations. A situation where one spouse knows they are filing for divorce, but the other spouse does not, differs from a scenario where both spouses know that divorce is unavoidable. *Structural context* includes the larger, societal context "within which" negotiations take place (Strauss, 1978, pp. 98-99). A central tenet of the negotiated order approach is that the relationship(s) between negotiation and negotiation context and between negotiation context and structural context is/are reciprocal. As such, the flow of influence can move from the microlevel (negotiations) to the macrolevel (structural context) or vice versa (Strauss, 1978, p. 101).

Application to Current Study

The author chose to use symbolic interaction theory as a conceptual framework for this study for several reasons. Beginning on a foundational level, because symbolic interactionism promotes a fluid, processual view of reality that is constantly changing according to symbols and meanings that individuals, groups, and society assign to it, symbolic interaction theory readily lends itself for use in studies that are qualitative in nature and seek to generate new theory to be used in understanding human behavior. Because the methodology of this study utilized a combination of phenomenological and grounded theory approaches when examining and interpreting study subjects' data, symbolic interactionist theory was a good fit.

Second, the author was drawn to symbolic interaction theory because of the profound ways in which it frames the individual and collective experiences of this study's sample. In particular, the author was thrilled to discover that this theory offered the means through which these individuals' lived experiences, could be understood, shedding light on how they develop and assign meaning to self, identities, and roles; it also illuminates how these meanings constantly vary across contexts according to these individuals' perceptions and interpretation, acceptance and rejection, sometimes resulting in maladaptive behaviors such as substance abuse.

In addition to criteria presented above, the author felt that symbolic interactionism was an appropriate choice for this study because of how it can be applied to research. Because symbolic interactionists view study subjects as the authors of social action and the creators of social organization, they appreciate and seek and understand their lived experiences (Reinarman, 2012). From a symbolic interactionist perspective, human

beings are seen as interpretive creatures that make sense of the world around them according to the meaning(s) they themselves create to interpret it. Symbolic interactionists see subjects as being in the position of constantly assessing, resisting, and theorizing about the circumstances they confront moment to moment and day by day; the understanding(s) subjects develop in these contexts are then used to inform their behavior (Wellman, 1988). In addition, symbolic interactionists believe that by taking a participant-observer role and allowing study subjects to be the experts about their own lives, they are able to gain access to information and knowledge that would otherwise be unavailable (Reinarman; 2012).

In conclusion, the subjects included in this study came to treatment having developed and assumed a wide range of individual and collective identities and roles. They are fathers, husbands, brothers, and sons; they are criminals, inmates, thieves, and addicts; they are businessmen, college graduates, lawyers, and athletes; they are gay, straight, bisexual, and questioning; they are human beings. It is the belief of the author that using symbolic interactionism as a conceptual framework for this study made it possible for real insights to be gained into the substance abuse treatment experiences of these men. For the purposes of this study, the contextualization, interpretation, and understanding of these subjects' experiences was facilitated through the application of the concepts and ideology of symbolic interaction theory.

CHAPTER THREE

REVIEW OF LITERATURE

Because this study examined different factors that contributed to or detracted from the substance abuse treatment experience of men who have sex with men, it was important to the author that a thorough review of current literature on men's substance abuse generally, and on gay men's substance abuse specifically, was presented. First, research on the phenomenon of substance abuse and dependence will be presented; this section will include research highlighting statistics on its frequency, its broad demographic impact across social groups, and the need that this phenomenon has created for more effective substance abuse treatments to combat its rising familial, financial, and societal costs. Second, the phenomena of substance abuse and substance dependency will be defined, using current mental health and behavioral criteria put forth by the American Psychiatric Association (APA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Third, current research and statistics on men's substance use and abuse will be presented; this section will highlight some of the uniquely male contributors that influence men's substance abuse and men's attitudes about treatment. Fourth, studies exploring gay men's substance abuse will be discussed, including a brief overview of reparative therapies, factors that contribute to higher rates of substance use/abuse among gay men, and some research highlighting successful treatments for gay men.

Substance Abuse

Substance abuse and dependency is becoming ever more prevalent in American

society and throughout the world. According to the 2014 National Survey on Drug Use and Health (NSDUH), more than 24.6 million people over the age of 12 in the United States alone, report having some sort of substance abuse or dependence problem (SAMSHA, 2014); 80% of those surveyed reported alcohol as their substance abuse issue in 2014 and 7 million of those surveyed reported that they were dealing with a drug problem in 2013 (SAMSHA, 2014). Of this group, 21.6 million Americans over the age of 12 were classified with *substance abuse or dependence* using the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition in 2013 (SAMSHA, 2014). These figures represent a number that is exponentially larger than the 14 million Americans over the age of twelve reporting substance abuse issues in 2002 (U.S. Department of Health and Human Services, 2002).

The Diagnostic and Statistical Manual of Mental Disorders (4^{th} ed.) defines such problems as maladaptive patterns of alcohol or drug use that result in significant adverse consequences at home, school, in the work place, or in one's interpersonal relationships (American Psychiatric Association, 2000). According to Liddle and Dakof (1995), substance abuse disorders are a daunting threat to public health. Along with the physical and psychological costs for the abuser, his or her family, and the community, substance abuse also leads to monetary costs such as job loss and financial strain. It also negatively affects society, resulting in victims of drug-related crime and accidents, and in the financial burdens incurred by costs of law enforcement, incarceration, and treatment (Lipsitt & VandenBos, 1992).

The National Institute on Drug Abuse (NIDA) reports that substance abuse costs the United States over 100 billion dollars each year, an estimated increase of over 50%

since 1985 (NIDA, 1998). In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) notes that drug treatment costs for marijuana, heroin, and amphetamine abusers have increased exponentially in recent years, along with the associated need for treatment services (SAMHSA, 2014; SAMHSA, 2013; SAMHSA, 1999). These statistics clearly indicate a growing need for developing more effective substance abuse treatments.

In response to a growing need for more effective substance abuse treatment programs, researchers have been examining how drug and alcohol use, dependency, and addiction affects different segments of society. The results of such studies indicate that substance abuse does not discriminate on the basis of age, gender, ethnic background, socioeconomic status, religious affiliation, or sexual orientation (Rowe & Liddle, 2002; Stanton & Todd, 1982). However, they also indicate that while substance abuse issues have varying degrees of impact on different societal groups, some are more vulnerable to their influence due to various behavioral and cultural factors (Connors, Donovan, & DiClemente, 2001; Halktis & Jerome, 2008; Rowe & Liddle, 2002; Stanton & Todd, 1982). One such group that appears to be especially hard hit by the effects of substance abuse is gay men.

Defining Substance Abuse and Dependence

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2013) describes substance abuse as a problematic pattern of substance use that becomes visible through the appearance of significant and repetitive adverse consequences as a product of the ongoing use of substances (p. 24). According to the Diagnostic and

Statistical Manual of Mental Disorders, Fourth edition (DSM-IV-TR) (APA, 2000a), substance abuse is characterized by a "maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (p. 198). The DSM-IV-TR (2000a) also differentiates the diagnostic criteria for substance abuse from that of substance dependence, stating that it does not include "tolerance, withdrawal, or a pattern of compulsive use" (p. 198).

The National Institute on Drug Abuse (NIDA) describes substance dependence as a state in which an organism can only function normally in the presence of a drug, that is manifested with the appearance of physical disturbances or withdrawal symptoms when the drug is removed (NIDA, 1998). In like manner, in the DSM-IV-TR (APA, 2000a) substance dependence is defined as a "maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by a need for increasing amounts of the substance to achieve intoxication, markedly diminished effect of the substance with continued use, the need to continue to take the substance in order to avoid withdrawal symptoms, and other serious behavioral effects, occurring at any time in the same 12-month period" (p.192).

Although the men comprising the sample in this study received treatment for their substance abuse issues in accordance with the diagnostic criteria set forth in the DSM-IV-TR regarding substance abuse and dependence (APA, 2000a), it is important to note, for completeness in this review of literature, that the American Psychiatric Association (2013b) now defines substance abuse and dependence in a new way. In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (APA, 2013b), when assessing for and treating issues related to substance abuse and dependence, the terms

substance abuse and substance dependence are no longer used. Instead, both phenomena belong to a group substance-specific, substance use disorders, which are categorized as mild, moderate, or severe according to the number of diagnostic criteria met by the individual being treated (APA, 2013b).

According to the DSM-5 (2013a), a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria in relationship to an individual's substance use. In addition, in the DSM-5 (2013a), an individual's behavior is given the diagnosis of substance use disorder when the repeated use of drugs and/or alcohol causes clinically and functionally significant impairment, such as failure to meet major responsibilities at home, work, or school, and health problems or disability.

Men and Substance Abuse

Research indicates that regardless of age or race, men use drugs and alcohol more often, and in larger amounts, than women do (Hammer, Vogel, & Heimerdinger-Edwards, 2013; SAMHSA, 2013; Weinberg, 1994). Substance abuse treatment services were originally designed with only male clients in mind. This was because the vast majority of individuals admitted to substance abuse treatment programs at that time were men (SAMHSA, 2014; SAMHSA, 2013; SAMHSA, 2006). In like fashion, additional research shows that young adults are more likely to use and abuse substances than older adults (Friedman, Terras, & Glassman, 2000). According to a National Survey of Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Association (SAMHSA) in 2008, young men, ages 18 to 25 are also more likely

to consume alcohol (64.3 percent) than their female counterparts (58.0 percent) (SAMHSA, 2009). Binge drinking is also more common among male drinkers. The findings reported in an earlier NSDUH survey (SAMHSA, 2005) indicated that 32.9 percent of men age 21 and older reported binge drinking during the past month, while only 14.7 percent of women age 21 and older reported binge drinking in the same time frame. Individuals who participate in binge drinking have a higher incidence of alcohol-related problems than those who don't, and men are more likely to binge drink than women (SAMSHA, 2005).

Studies show that American men are two to five times more likely to develop substance use disorders than American women (Brady & Randall, 1999; Johnson & Glassman, 1998; SAMHSA 2008; SAMHSA 2005). In fact, men experience greater mortality and morbidity in developed nations around the world from the use of alcohol and tobacco products than female users in these countries, due in part to higher rates of use (Lopez, 2004). In addition, it has been reported that the economic cost of men's substance abuse is greater than the cost generated by their female counterparts (Harwood, Fountain, Carothers, Gerstein, & Johnson, 1998; SAMSHA, 2014; SAMSA, 2013). Research in this area offers two possible explanations for this phenomenon: (1) male substance abusers require more criminal justice system involvement, and (2) because male substance abusers are more often employed, they require more disability payments when they are injured on the job or take leave to seek treatment (Harwood et al., 1998; Oggins, Guydish, & Delucchi, 2001; Timko, Moos, & Moos, 2009). Ironically, taxpayers in this country benefit when men choose to receive substance abuse treatment. A study

conducted by Harwood et al. (1998) found that an estimated $9.00 is saved in disability, welfare, healthcare, and criminal justice costs for every dollar spent on treatment.

Men and women are equally likely to use drugs and/or alcohol when the opportunity presents itself. However, studies show that men may be more likely than women to use and abuse them largely because they have more opportunities to do so (Brooks, 2001; Van Etten, Neumark, & Anthony, 1999; SAMHSA, 2008). In addition, men generally begin experimenting with drugs alcohol at an earlier age than women do (SAMHSA, 2005). These sociocultural factors could provide a partial explanation for higher rates of substance abuse and dependence among men. Men's and women's reasons for substance use are also different. Traditional male institutions such as sports teams, motorcycle gangs, or fraternities, often promote and/or encourage alcohol use (Brooks, 2001). Men often use substances to deal with pain or difficult emotions or if they feel like that cannot adequately manage or express their feelings (Cheng, 2003; Connors et al., 2001; Van Etten et al., 1999). The experience of feelings of shame and guilt can adversely influence men's help-seeking behaviors for mental health or substance use disorders (Brooks, 2001; Evans & Sullivan, 2001; Hammer, Vogel, & Heimerdinger-Edwards, 2013; Rabinowitz & Cochran, 2001; Pollack, 1998).

Having an understanding of how socially constructed gender role expectations influence men's attitudes toward their substance(s) of choice can be helpful to drug and alcohol counselors, marriage and family therapists, and behavioral health service providers in selecting the most effective treatment strategies (Hammer, Vogel, & Heimerdinger-Edwards, 2013; Rabinowitz & Cochran, 2001; SAMHSA, 2014; SAMHSA, 2013). The consumption of alcohol, for example, is traditionally associated

with conceptions of masculinity and masculine activities. A young man's a first drink or first drunk is often considered a rite of passage (Blazina & Watkins 1996; Hunt et al., 2005), and drinking is commonly seen as a form of male bonding (West, 2001). These traditional ideas that connect masculinity to drinking can be easily identified across cultures (Carter & McGoldrick, 1999; Heath, 2000) and are associated with greater alcohol consumption among college men (Blazina & Watkins 1996; West, 2001) and among military servicemen (Burda et al., 1992; West, 2001).

Treatment and Gay Men

Although researchers have observed that gay men report a much higher rate of substance abuse than other groups in the general population (Cabaj, 2008; Cheng, 2003; Flentje, Heck, & Sorensen, 2015), comparatively few self-identified gay men seek treatment for their substance abuse issues (Bakker, Sandfort, VanWessenbeeck, & Westert, 2006; Mackesy-Amiti, Fendrich, & Johnson, 2009; SAMSHA, 2014). Out of those that do, very few reveal their sexual preference during treatment, fearing judgment, harassment, or even a violent response from their counselors or fellow clients (Hellman, Stanton, lee, Tytun, & Vachon, 1989). From the psychosocial and environmental perspectives, several possible contributors to the high rate of substance abuse among gay men readily present themselves. Some of these include: the impact of the gay bar scene (Steven-Smith & Smith, 1998; Weinberg, 1994), non-acceptance of self and the internalization of society's homophobia (Baker, 2002; Hardin, 1999; Hilton, 1992; Warn, 1997; Weinberg, 1972), the experience of childhood sexual abuse (Bass & Davis, 1988; Klinger & Stein 1996; Lopez-Patton et al., 2016; Neisen & Sandall, 1990), difficult

coming-out experiences, coupled with possible judgement or rejection from family members, friends, institutions, or society as a whole (Benshoff & Janikowski, 2000; Cheng, 2003; Herek, 1996; Russell & Fish, 2016), and the effect(s) and impact(s) of HIV/AIDS (Brendstrup & Schmidt, 2002; Cabaj, 2008; Hogan & Hudson, 1995; Phillips et al., 2014).

With regard to treating both adolescent and adult substance abuse issues, family-based treatments are currently seen as some of the most effective (Cheng, 2003; Malley & Tasker, 2004; Rowe & Liddle, 2002; Russell & Fish; 2016; Williams & Stanton & Shaddish, 1997). Stanton and Todd (1982) indicate that families play important roles in drug abuse initiation, escalation, and recovery. In light of these roles, family members can provide feedback that will help the abuser both initiate and maintain abstinence. When working with gay men in therapy, researchers also stress the importance of familial participation and support in achieving more positive therapeutic outcomes (Bepko & Johnson, 2000; Johnson & Keren, 1998; Sanders & Kroll, 2000). Because gay men are often marginalized by a hostile dominant culture, biological family members and members of the gay community may be their most critical source(s) of support (Johnson & Keren, 1998; Malley & Tasker, 2004; Williams, 2014). Current research in this area also indicates that, due to the unique psychological, cultural, and environmental factors that can contribute to gay men's substance abuse issues, the treatments used to address them must be tailored to meet their specific needs (Cabaj, 2008; Cheng, 2003; Flentje, Heck, & Sorensen, 2015; Logan & Barret, 2006; Rathbone-McCuan & Stoke, 1997).

Sexual Orientation as the Problem

When looking at effectiveness research on substance abuse treatment programs for gay men, it is important to have some knowledge of how homosexuality has been, and is currently, viewed by those in the mental health professions. Before 1973, homosexuality was classified in the Diagnostic and Statistical Manual of Mental Health Disorders, Second Edition (DSM-II), as a "category of disorder" (Spitzer, 1981). Societal norms at that time dictated that standard substance abuse treatment protocol(s) for those dealing with homosexuality included "re-orienting" their sexual orientation before addressing their substance abuse issues (Cheng, 2002; Cheng, 2003; Spitzer, 1981).

However, in time, when data from researchers such as Alfred Kinsey and Evelyn Hooker were presented, attitudes about and understanding of homosexuality began to change (Spitzer, 1981). In 1974, the seventh printing of the DSM-II, no longer listed homosexuality as a category of disorder. After a vote by the trustees of American Psychiatric Association in 1973, which was later ratified in 1974 by wider APA membership, homosexuality's category of "disturbance" was replaced with the category of "sexual orientation disturbance" (Spitzer, 1981). When the American Psychiatric Association removed homosexuality from its list of mental disorders in 1973, new treatments protocols emerged to include appropriate ways of helping gay clients live healthy, drug-free lives, while professionally dealing with the stigma attached to their sexual orientation (Cheng, 2002; Cheng 2003; Flentje, Heck, & Sorensen, 2015; Russell & Fish, 2016).

Despite the considerable strides society has made in recent years both in understanding and in accepting homosexuality, current research in this area indicates that when LGBTQ individuals reveal their sexual preferences and identities during treatment, they are not supported and are often encouraged to change or discount their homosexual thoughts and feelings (Gibson, 1989; Haldeman, 1999; Haldeman, 2002). Many mental health providers still assume that a gay client's sexual orientation is the "true" cause for his/her substance abuse issues. In line with these assumptions, they may wish to alter a client's orientation from gay to heterosexual before attempting to treat their substance abuse issues (Cheng, 2002; Cheng 2003; Fjelstrom, 2013; Gibson, 1989; Haldeman, 1999; Haldeman, 2002).

Studies show that up to 85 percent of gay, lesbian, and bisexual individuals in the United States grow up in a "homonegative" religious context (Flentje, Heck, Sorensen, 2015; Plugge-Foust &Strickland, 2000; Russell & Fish, 2016; Schuck & Liddle, 2001). These contexts often support worldviews that see a need for sexual orientation change efforts (SOCE). According to the American Psychological Association (2009), when a same-sex attracted individual's environment is homonegative, they often choose to mask their feelings, making it extremely difficult to live an authentic, healthy life as a non-heterosexual person (American Psychological Association, 2009). In addition, research indicates that when gay individuals realize that their inner thoughts, feelings, and experiences do not conform to the expectations of his/her dominant discourse, they experience emotional and psychological effects that result in cognitive dissonance (Cabaj, 2008; Herek, 1996; Rodriguez, 2010). As a result, many of these individuals

seek to resolve these issues by seeking some form of reparative or reorientation therapy to change their sexual orientation (Cheng, 2002; Cheng, 2003; Fjelstrom, 2013).

The American Psychological Association (2009) currently uses the term sexual orientation change efforts (SOCE) when referring reparative or conversion therapies. These treatment approaches attempt to change an individual's sexual orientation from homosexual to heterosexual through the use of behavioral modification, counseling, cognitive reframing, religious practices, and other means (Fjelstrom, 2013; Haldeman, 2002; Schneider, Brown, & Glassgold, 2002; Throckmorton, 2002; Yarhouse & Burkett, 2002). Proponents of SOCE believe that through the consistent application of these techniques, they can gradually reduce, and, eventually eliminate clients' same-sex attractions (Haldeman, 2002).

Most advocates of reparative therapies assume that a homosexual orientation is invalid (Cheng, 2002; Cheng, 2003; Throckmorton, 2002; Yarhouse & Burkett, 2002). Their efforts are guided by the notion that a same-sex orientation is the result of serious trauma or a dysfunctional childhood and maintain that same-sex behavior is chosen, unnatural, abnormal, and sinful (Cheng, 2002; Cheng; 2003; Fjelstrom, 2013). The ultimate goal of reparative or reorientation therapies is that the affected individual will begin to identify as heterosexual because it is believed that heterosexuality is each person's "true" orientation (Cheng, 2002; Cheng, 2003; Throckmorton, 2002; Yarhouse & Burkett, 2002).

In recent years, the practice of reparative or conversion therapy has been discredited by several professional organizations including the American Psychological Association, the American Counseling Association, and the National Association of

Social Workers (American Psychological Association, 2006). In their Position Statement on Therapies Focused on Attempts to Change Sexual Orientation, The American Psychiatric Association (2000b) states that it "opposes any psychiatric treatment, such as 'reparative' or conversion therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation" (para. 1).

Effective Treatments for Gay Men

A large body of research has established that substance abuse treatments can be effective in treating the substance abuse problems of various populations (Benshoff & Janikowski, 2000; Connors, Donovan, & DiClemente, 2001; Liddle & Dakof, 1995; Rowe & Liddle, 2002). Several studies within this body of research demonstrate that substance abuse treatments, specifically designed for gay men, can also be effective (Bux & Irwin, 2006; Cheng, 2003; Bakker et al., 2006; Halktis & Jerome, 2008; Hellman et al., 1989; Klinger & Stein, 1996; Mobley & Liu, 2004; Reback & Shoptaw, 2014; Schneider, Brown, & Glassgold, 2002). Some such studies illustrating the effectiveness of substance abuse treatment(s) for gay men will be presented here, grouped in following three areas: (1) special populations/race, (2) gay culture/club drug scene, and (3) HIV prevention and education.

Special Populations/Race

Most researchers that have studied substance abuse issues in the gay community agree that studying gay men requires some special considerations (Bepko & Johnson,

2000; Bux & Irwin, 2006; Cheng, 2002; Cheng, 2003; Johnson & Karen 1998; Logan & Barret, 2006; Sanders & Kroll, 2000). As a group, gay men face several unique challenges and struggles that set them apart from the general population. Some of these challenges include internal and external homophobia, the heterosexist norms, values, and expectations of the dominant culture, and an overall lack of certain civil rights, protections, and liberties under the law (Cabaj, 2008; Cheng, 2002; Flentje, Heck, & Sorensen, 2015; Haldeman, 2002). In light of these factors, some research has been done to discover ways in which mental health professional can better serve gay men in treatment.

In August of 2001, the 49th division of the American Psychological Association met in Hawaii to discuss working with diverse populations. They concluded that gay men particularly presented psychotherapists with some specific challenges. These included dealing with HIV/AIDS and substance abuse issues (Trammel, 2001). It is important to note that not all gay men are alike when designing future research. Mobley and Liu (2004) assert that in order to develop a more complete profile of racial/ethnic and gay male substance abusers, the social class, age, and geographic location of culturally distinct groups of men must be examined. Then, through linking these factors with aspects of culture, masculine socialization and masculine role development, and substance abuse, a deeper understanding of this population can be developed.

Striving to gain a more culturally complete profile for gay male substance abusers, Halktis and Jerome (2008) conducted a comparative analysis of methamphetamine use between Black bisexual/gay men and bisexual/gay men of other races. Drawing upon information gathered from 300 Black bisexual/gay men over 18

years of age, they discovered that 49% had used methamphetamine in the last 4 months. This percentage was proportionately lower than that of their White counterparts. In this same study, Halktis and Jerome (2008) discovered that although gay Black methamphetamine users did not usually live in traditionally gay neighborhoods, they had lower levels of education and income and were more likely to be HIV-positive than gay men in other ethnic groups included in the study. In light of these findings, they emphasize that because of the synergy that exists between methamphetamine use and abuse, sexual disinhibition, and the Black community, using this drug, specifically, presents a mounting challenge to public health (Halktis & Jerome, 2008).

Gay Culture/Club Drug Scene

For many gay men, simply coping with the reality of being gay leads them to seek out mind-altering substances, which later lead them to substance abuse issues (Baker, 2002; Cabaj, 2008; Cheng, 2003; Flentje, Heck, & Sorensen, 2015; Hardin, 1999; Herek, 1996). Gay culture is often associated with heavy alcohol consumption and drug use. Numerous studies have been conducted to better understand substance abuse among gay men and what treatments can be effectively employed to deal with it. Some such studies indicate that different behavioral therapies are effective in reducing both substance use and risky sexual behaviors in gay men (Hoenigl, Chaillon, Moore, Morris, Smith, & Little, 2016; Jaffe, Reback & Shoptaw, 2014; Shoptaw, Stein, Reback, & Rotheram-Fuller, 2007; Peck, 2005; Shoptaw, Reback, Larkins, Wang, Rotheram-Fuller, Dang, & Yang, 2008; Shoptaw & Yang, 2005).

Shoptaw et al. (2008) conducted a 16-week trial of four different behavioral therapies to see which therapies effectively helped gay and bisexual men reduce their methamphetamine use and risky sexual behaviors. 162 gay and bisexual men (GBM) who identified themselves as meth addicts were recruited from the West Hollywood, California area. Each recruit was randomly assigned to one of four behavioral therapies: contingency management (CM), cognitive-behavioral therapy (CBT), CM +CBT, or gay cognitive-behavioral therapy (GCBT). In CM, clients were given grocery vouchers, clothing, or transportation as incentives, upon giving clean urine samples. In CBT, clients examined possible environmental and emotional triggers associated with using drugs and relapse, and were taught coping strategies to help them cope with cravings and thoughts that could lead them to use. In GCBT, clients focused on developing coping skills for cravings, relapse, and maintaining a healthy lifestyle utilizing examples from gay cultural events and environments (Shoptaw et al., 2008).

Although all 4 behavioral therapy approaches benefited the study participants, Shoptaw and his colleagues (2008) found that clients treated with GCBT submitted more substance-free urine tests than those treated with traditional CBT. In addition, clients treated with GCBT reported engaging in less anal receptive intercourse—known to spread HIV/AIDS—than clients treated with CBT. Overall, by the end of their 16-week trial, Shoptaw et al. found that treating gay and bisexual methamphetamine-using men with behavioral therapies produced some very promising results. Study participants' dirty urine tests fell by 31 percent and they reported a 50 percent decrease in past-month sexual partners. Study participant also reported that their depression symptoms had improved (Shoptaw et al., 2008).

Although the primary focus of most substance abuse treatment programs is complete abstinence from the use drugs and/or alcohol, many clients present for treatment with high levels of depression, anxiety, and sexual risk behaviors that can interfere with the process of recovery (Hoenigl et al., 2016; Jaffe, Shoptaw, Stein, Reback,&Rotheram-Fuller, 2007; Shoptaw et al., 2008). Jaffe, Shoptaw, Stein, Reback, & Rotheram-Fuller (2007) examined the relationship between methamphetamine use, sexual risk behaviors, and depression symptoms in methamphetamine-dependent, gay and bisexual men (GBM). Using a sample of 145 GBM enrolled in a 16-week outpatient drug treatment program who were being treated with 4 different behavioral therapies: (1) contingency management (CM), (2) cognitive-behavioral therapy (CBT), (3) CM + CBT or (4), gay cognitive-behavioral therapy (GCBT), Jaffe et al. (2007) monitored client methamphetamine use as a predictor for depression and risky sexual behaviors using latent growth curve models. At the end of the 16-week treatment program, they found that participants reporting increased abstinence from methamphetamine use (urine verified) also reported experiencing lower levels of depression and sexual risk behaviors. In addition, Jaffe et al. (2007) found that clients treated with gay cognitive-behavioral treatment (GCBT) experienced a more rapid decrease in methamphetamine use and its associated symptoms than those clients treated with the other three behavioral therapy models (CM, CBT, CM+CBT).

HIV Education and Prevention

Since the first cases of Acquired Immunodeficiency Syndrome (AIDS) were diagnosed in the early 1980s, it has had an especially profound impact on the lives

members of the LGBTQ community. Current research in this area clearly identifies a correlation between gay, substance- abusing men and the spread of HIV/AIDS (Cabaj, 2008; Cheng, 2003; Halktis & Jerome, 2008; Jaffe et al., 2007; Phillips et al., 2014; Shoptaw et al., 2008). Because of this correlation and the threat posed by HIV/AIDS to public health and society, several studies have been conducted to specifically address substance abuse among gay men and the spread of HIV/AIDS.

When striving to decrease high-risk sexual behaviors that can lead to contracting or spreading HIV/AIDS, clinicians working with gay, substance-abusing men must first address the clients' substance abuse issues. Education about the connection between substance abuse and the spread of HIV/AIDS becomes secondary (Bux & Irwin, 2006; Cheng, 2002; Cheng, 2003). In an effort to address these issues, Bux and Irwin (2006) combine motivational interviewing (MI) with cognitive-behavioral skills training (CBTST). In describing the application of their model, these authors strongly emphasize that clinicians must first address the fundamental skills the client needs to acquire and to maintain abstinence from drugs and alcohol. Bux and Irwin (2006) then state that clinicians must assess the client's motivation to change his behavior. They assert that utilizing this combined model (MI+CBTST) will enable clinicians to help clients attain abstinence from drugs and alcohol, and then create the lasting behavioral change(s) that will aid them in leading more productive, healthful lives (Bux & Irwin, 2006).

Treating gay, substance-abusing men who have not yet contracted HIV, or who are HIV-, can be very different than treating gay, substance-abusing men who are already living with HIV/AIDS. Wong, Rotheram-Borus, Lightfoot, Pequegnat, Comulada, Cumberland, Weinhardt, Remien, Chesney, and Johnson (2008) conducted a study with

936 HIV-infected individuals (HII) to test the effectiveness of what they call an *intensive intervention*. Their sample was comprised of both male and female, heterosexual and homosexual, substance-abusing HIIs, who had recently engaged in unprotected sexual acts. The *intensive intervention* was comprised of 15 individual case-managed sessions with a therapist. Some study participants received the intensive intervention treatment, while others, serving as a control group, did not (Wong et al., 2008).

Wong and his colleagues (2008) found that HIIs who received the intensive intervention treatment had drastic reductions in reported substance use than did HIIs in the control group, who did not receive the intensive intervention treatment. While the intervention-related substance abuse reductions were larger among women than men, these researchers found that men's substance abuse was also reduced (Wong et al., 2008). When compared to gay men in the control group, gay men who had received the intensive intervention treatment also reported dramatically reducing their drug use. These authors conclude that using a case management intervention model like the *intensive intervention*, delivered individually, can lead to significant decreases in substance abuse in individuals living with HIV/AIDS (Wong et al., 2008).

Summary

The body of literature presented here clearly demonstrates that substance abuse and dependency is a serious issue that is quickly becoming more prevalent both here in the United States and throughout the world. Some of those who become involved with it face disastrous, often life-altering consequences (SAMSHA, 2014; SAMHSA, 2013). According to Liddle and Dakof (1995), substance abuse and its related disorders are fast

becoming a daunting threat to public health. In addition to resulting in considerable costs for the abuser, his or her family, and the community, substance abuse leads to job loss, financial strain, and physical and psychological problems. It also negatively affects society, resulting in victims of drug-related crime and accidents, and in the financial burdens incurred by costs of law enforcement, incarceration, and substance abuse treatment (Lipsitt & VandenBos, 1992). The research highlighted here also clearly indicates an immediate need for the development of more effective treatments for substance abuse and calls for the implementation effective solutions for its inherent consequences.

The research presented here also indicates men experience a higher rate of substance use and substance abuse than women (Brady & Randall, 1999; Johnson & Glassman, 1998; SAMHSA 2008; SAMHSA 2005) and that more money is spent on men's incarceration and substance abuse treatment than that of women (Harwood et al., 1998; Oggins et al. 2001; Timko et al. 2009). Some explanations for this reality include: exposure to drugs and alcohol at an earlier age (Brooks, 2001; Van Etten et al., 1999; SAMHSA, 2014; SAMHSA, 2005), socially constructed ideas about masculinity and masculine roles that are strongly linked to alcohol and alcohol consumption, and difficulties managing and expressing emotion (Cheng, 2003; Connors et al., 2001; Van Etten et al., 1999). This research also named the experience of shame and guilt as having a negative influence on men's help-seeking behaviors for mental health and/or substance use disorders (Brooks, 2001; Evans & Sullivan, 2001; Hammer, Vogel, & Heimerdinger-Edwards, 2013; Rabinowitz & Cochran, 2001; Pollack, 1998).

This body of literature confirms that there are specific factors contributing to a higher incidence of substance abuse and substance abuse-related issues among gay men. Some of these include: the impact of the gay bar scene (Steven-Smith & Smith, 1998; Weinberg, 1994), non-acceptance of self and the internalization of society's homophobia (Baker, 2002; Hardin, 1999; Hilton, 1992; Warn, 1997; Weinberg, 1972), the experience of childhood sexual abuse (Bass & Davis, 1988; Klinger & Stein 1996; Lopez-Patton et al., 2016; Neisen & Sandall, 1990), difficult coming-out experiences resulting in the ultimate rejection of the gay individual by family members, friends, institutions, and society (Benshoff & Janikowski, 2000; Herek, 1996), and the effect(s) of HIV/AIDS (Brendstrup & Schmidt, 2002; Cabaj, 2008; Cheng, 2003; Hogan & Hudson, 1995; Phillips et al., 2014). Taken individually and/or collectively, it can be easily understood how these factors can/do lead people to seek out maladaptive or detrimental coping mechanisms such as substance abuse.

This review of literature clearly indicates that family-based treatments are currently seen as some of the most effective ways of treating both adolescent and adult substance abuse issues (Malley & Tasker, 2004; Rowe & Liddle, 2003; Williams & Chang, 2000; Stanton & Shaddish, 1997). With regard to working with gay men in treatment, research shows that family involvement is extremely important. One reason mentioned in the literature is that because gay men are often marginalized by a hostile dominant culture, biological and community family may be their most critical source of support (Johnson & Keren, 1998). Research in this area indicates that family participation and support is an important part of achieving positive therapeutic outcomes (Bepko & Johnson, 2000; Johnson & Keren, 1998; Sanders & Kroll, 2000).

In conclusion, the research highlighted here clearly indicates that men who have sex with men have a larger predisposition to develop substance abuse problems than other groups (Cabaj, 2008; Cheng, 2003; Flentje, Heck, & Sorensen, 2015; Mobley & Liu, 2004). Several factors are highlighted here that, taken together, provide insight into why substance abuse issues impact these men so heavily (Cheng, 2003; Baker, 2002; Benshoff & Janikowski, 2000; Hilton, 1992; Warn, 1997). This same research indicates that men who have sex with men seldom seek treatment for their substance abuse issues (Bakker, Sandfort, VanWessenbeeck, & Westert, 2006; Mackesy-Amiti, Fendrich, & Johnson, 2009). Therefore, it is easy to see why qualitative studies like this one are important in providing much-needed insight into the substance abuse treatment experience(s) of men who have sex with men. In addition, it is hoped that this study can shed additional light on factors that contribute to or detract from this population's desire or ability to seek treatment, when needed. As such, the findings of this will study provide critical information and insight needed to better understand the substance abuse treatment experience(s) of men who have sex with men so that clinicians, substance abuse counselors, marriage and family therapists, and other rehabilitation treatment staff members can offer them the most informed and impactful treatment possible.

CHAPTER FOUR

METHODS

This study employed a qualitative research design, drawing upon concepts from phenomenology (Flick 2006; Moustakas, 1994; Smith, Flowers, Larkin, 2009) and grounded theory (Corbin & Strauss, 2008; Strauss & Corbin, 1990; Walsh, Holton, Bailyn, Fernandez, & Glaser, 2015). The design of this study was divided into two phases. In Phase I, a case analysis of the 24 client cases that constitute this study's sample was conducted. In Phase II, qualitative member check interviews (Flick 2006; Lincoln & Guba, 1985; Moustakas, 1994), conducted with six study subjects who fit the inclusion criteria, were audio recorded, transcribed, and analyzed to add validity, transferability, and clarification to the results of the case analysis (Guba, 1981; Smith, Flowers, & Larkin). During both Phases I and II, a grounded theory approach (Corbin & Strauss, 2008; Strauss & Corbin, 1990; Walsh et al, 2015) was employed to analyze, code, and interpret study participants' case and interview data to create new theory about their substance abuse treatment experiences and to identify factors that contributed to positive or negative posttreatment outcomes.

In designing the methodology of this study, the researcher opted to draw upon concepts from phenomenology and grounded theory because of the commonalities they share in how they seek to understand people's lived experiences (Corbin & Strauss, 2008; Holloway & Parahoo, 2006; Strauss & Corbin, 1990; Walsh et al., 2015). The commonalities pertinent to this study include: (1) each approach seeks to explore individuals' experiences in the context of the worlds in which they live, (2) both seek to collect and analyze data from participants' perspectives in an effort to protect their

findings from preconceived ideas or outside influences, and (3) each of these methodologies often involves study participants in data analysis (i.e., member check interviews) to increase the trustworthiness of their findings (Corbin & Strauss, 2008; Holloway & Todres, 2010; Todres & Holloway, 2010). This shared methodological perspective fit very well with the goal of understanding the individual and collective substance abuse treatment experiences of sample subjects, and simultaneously allowed for the generation of a new theory around factors that contributed to or detracted from their experiences.

The focus of this study and its attending research questions was enhanced by the ability of the researcher to assume the role of an "observant" participant, or one who is part of the group (Bolton, 1995; Kaminski, 2004), to fully observe and understand the substance abuse treatment experience of study participants. The term "observant" participant is being used in lieu of "participant observer" (Mead, 1928; Glaser & Straus, 1967) to highlight the way in which the researcher's partial or full membership in the community/subculture that he was examining both allows a different sort of access to the community while simultaneously shaping his perceptions in different ways from those of a full outsider (Bolton, 1995).

This study's qualitative research design was an appropriate way of examining the substance abuse treatment experience of men who have sex with men because it concerns itself with how notions of self, masculinity, roles, and identity are socially constructed and acquire meaning in relationships, in relationship to social institutions, and across groups (Blumer, 1966; Denzin & Lincoln, 2000; LaRossa & Reitzes, 1993; Meltzer & Petras, 1972; Schwandt, 2000). In addition, qualitative research methods seek to answer

questions pertaining to how social experience is created, assigned value, and given meaning, especially as it pertains to the accepted cultural mores and symbols attached to the concepts of self and masculine identity (Burgess, 1926; Cooley 1902/1956a; Mead, 1934; Schwandt, 2000; Waller, 1938). For in most cultures, including the one couching this study, only the most salient cultural and societal roles and the processes connected to them are viewed as true or valid. As such, most strive to lead lives—at least externally—that give the appearance of conforming harmoniously to them (Burgess, 1926; Hutter, 1985; LaRossa & Reitzes, 1993; Ratliff, & Lyle, 2000; Szasz, 1987).

Data Collection

Sample Selection

As has been previously stated, the researcher worked with men in a substance abuse treatment facility from June of 2008 until December of 2011 in the capacity of a marriage and family therapist trainee. This primary function at the facility was to conduct individual therapy sessions with any or all of the men that had a desire or a need to be seen. It was during this three and a half year period that a sample of 24 client cases emerged spontaneously with a similar subset of treatment needs that were not being adequately addressed in the larger residential group setting.

These unmet needs centered around the fact that all of these 24 men disclosed, during the course of individual therapy, that they each had sexual experiences with other men during their lifetimes before entering substance abuse treatment. Some sample members attributed their substance-related issues to these experiences, while others shared that they used "in order" to facilitate or to enhance them. Still others stated that

because of their sexual preference, such experiences and activities were a natural part of their lives, or a natural extension of their identities. With few exceptions, the men in this sample expressed the same concerns about their treatment experience. Most feared that sharing about their past sexual experiences or current sexual preferences would lead to negative or violent feedback from their client peers or treatment staff, to being rejected by family, spouses, or friends, and ultimately lead them to leave treatment before completing and/or to relapse. These 24 client cases became the sample used for the case review in Phase I of the current study.

Originally, the author was only going to conduct a review of these 24 client cases, using a phenomenological qualitative approach (Smith, Flowers, & Larkin, 2009). However, while working collaboratively with the primary investigator of this study, along with the members of his dissertation committee, he expanded the study design to include a member check interview (Lincoln & Guba, 1985; Moustakas, 1994) that would be conducted with a subset of as many available study participants from the original study sample as possible. It was the hope of the author and his committee members that the data resulting from both the case review and member check interviews would add validity and transferability to this study, enhancing its trustworthiness (Guba 1981; Moustakas, 1994; Corbin & Strauss, 2008; Smith, Flowers, & Larkin, 2009).

After repeated attempts were made to contact sample members by telephone and mail for participation in the member check interview with no success, the author employed snowball sampling to locate six men who were willing to be interviewed. All six of these study subjects were selected because they fit study inclusion criteria and reported having participated in residential substance abuse treatment programs.

Description of Participants

The participants taking part in this study comprise a diverse demographic of men. The sample included African American, Caucasian, Hispanic, and mixed race subjects. At the time of treatment, they ranged in age from 18 to 50 years of age and came from various educational, vocational, and socioeconomic backgrounds. Some came to treatment directly from the California State prison system, others from their homes, and others reported that they were homeless before seeking treatment for their substance abuse problems.

In addition to the above differences, the men included in this study represented varied family lifestyles and family constellations. Some study participants reported that they were married to heterosexual partners, while others reported that they were in committed relationships with or married to partners of the same sex. Some reported being fathers, while others reported being single and having no children. In spite of their varied educational, ethnic, cultural, and socioeconomic backgrounds, all of these men were included in the author's study sample because they shared one thing in common: during the course of individual therapy, they each disclosed that they had been sexually involved with men, and as such, maintained a similar set of feelings, concerns, and fears in connection with acknowledging or divulging that involvement during their treatment experience.

The sample's racial composition included: five African Americans, 13 Caucasians, three Hispanics, and three mixed race subjects. At the time of treatment, they ranged in age from 19 to 50, with a mean age of 40. Subjects' religious affiliation was reported in the following five categories: one Baptist, four Catholic, 12 Christian,

with four reporting "None" and three reporting "Other." Level of education achieved at the time of treatment fell into three primary categories: four reporting some high school education, seven reporting having obtained a minimum of a high school diploma, and 13 reporting having received some college and/or a college diploma. The sample subjects reported drugs of choice (DOC) fell into four categories: three alcohol, four heroin or prescription opiates, one marijuana, and 15 methamphetamines; six via smoking and nine via injection.

Additional demographic information gathered during intake and obtained during treatment included treatment referral source, relationship status, criminal history, sexual orientation, anticipated length of stay (LOS), and treatment completion and discharge information. At time of treatment, study subjects identified their referral sources in the following categories: 12 self-referred, three court-mandated, two medical referrals, two California Criminal Justice Department, two parole/Proposition 36 referrals, and two by family and friends. Subjects' relationship status was recorded in the following three categories: three as divorced, two as married, and 19 as never married or single. Subjects' criminal history at time of treatment fell into the following categories: four "none" or no criminal history, three on probation, five on parole, ten arrested in the last 24 months, and eight reported having had some criminal involvement before coming to treatment. Study subjects' sexual orientation was reported in the following categories: 12 heterosexual and 12 gay. Participants' anticipated length of stay in treatment was reported as: two (180 days), 15 (90 days), three (45 days), and four (30 days or less). Study subjects' program completion and discharge information was reported as: 17 completions, seven early discharges; six of those were discharged early for various

reasons, including non-compliance with program guidelines, medical or mental health issues, relapse, and leaving treatment early.

Because the six study subjects who participated in the member check interviews had received treatment in other facilities, their demographic information was gathered during each member check interview, and therefore varied slightly from that of the sample subjects above. The six member check interview participants ranged in age from 38 to 55, one was African American, two were Hispanic, and three were Caucasian. With regard to religious affiliation, one reported being Jewish, one as a Mormon, one as Catholic, and three as Christians. Three subjects reported methamphetamine via injection as their drug of choice when interviewed; three subjects reported alcohol as their drug of choice when interviewed. When interviewed, five subjects reported being single, while one reported that his was married to a male partner. All six interviewees reported identifying as gay men when interviewed, and all six reported having participated in substance abuse treatment programs and in post-treatment groups. When the findings of Phase II are presented, each of these study subject's transcribed quotations, thoughts, etc., will be referenced using the following alphanumeric identifiers: SS1, SS2, SS3, SS3, SS4, SS5, and SS6.

Study Design

As has been stated, this study utilized a qualitative phenomenological research design (Flick 2006; Moustakas, 1994; Smith, Flowers, & Larkin, 2009) divided into two phases to gain insight into the substance abuse treatment experiences of men who have sex with men. In Phase I, a case analysis of 24 existing client cases of such men was

Table 1. Demographic information for case review sample subjects

Subject	Age	Drug of Choice	Sexual Orientation	Length of Stay	Discharged
1.	19	Marijuana	G	180 Days	No
2.	28	Heroin	H	90 Days	No
3.	40	MethVI	H	90 Days	Yes
4.	27	Alcohol	G	90 Days	No
5.	49	MethVI	G	90 Days	Yes
6.	25	MethVS	H	45 Days	No
7.	40	MethVI	G	90 Days	Yes
8.	48	MethVI	H	28 Days	No
9.	43	MethVS	H	90 Days	No
10.	47	Alcohol	G	90 Days	No
11.	45	MethVI	H	90 Days	Yes
12.	29	Heroin	H	30 Days	No
13.	30	MethVS	G	45 Days	No
14.	42	Opiates	H	12 Days	No
15.	38	Alcohol	G	22 Day	Yes
16.	36	MethVS	H	90 Days	No
17.	29	MethVI	H	45 Days	Yes
18.	25	MethVS	H	90 Days	No
19.	48	MethVS	G	90 Days	No
20.	47	MethVS	G	180 Days	No
21.	42	Heroin	H	90 Days	No
22.	45	MethVI	G	90 Days	No
23.	33	MethVI	H	90 Days	No
24.	50	MethVI	G	90 Days	No

conducted. In the original study design for Phase II, member check interviews (Lincoln & Guba, 1985; Moustakas, 1994; Flick 2006), conducted with all available case review study participants, were to be audio recorded, transcribed, coded, and analyzed to add validity, transferability, and credibility to the data resulting from the case review (Guba, 1981). However, because no case review subjects responded to the telephone and mailed

invitations to participate in the study, six men meeting study inclusion criteria were found through snowball sampling and selected to participate in the member check interviews. During both Phases I and II, a grounded theory approach (Corbin & Strauss, 2008; Walsh et al., 2015) was used to analyze, code, and interpret study participants' case and interview data.

Phase I: Case Review

As stated previously, this study took place in two phases. In Phase I, the author conducted a phenomenological review of 24 cases that fit the study's inclusion criteria. Because the study subjects were engaging in the process of individual therapy during their substance abuse treatment experiences regular session notes had been recorded. In addition, once the study design began to take shape, additional process notes were written on each study subject in order to enhance study validity and credibility (Patton, 1990; Yin, 2003).

A phenomenological research approach was selected for use in conducting the case review for several reasons. The primary purpose of a phenomenological approach is to illuminate and identify phenomena through the actors' perception in a given situation (Moustakas, 1994; Lester, 1999; Smith, Flowers, & Larkin, 2009). In studies examining the human experience, this typically includes gathering participants' narratives and perceptions through inductive qualitative methods such as interviews, discussions, and participant observation, and then representing it from the perspective of the research participants (Corbin & Strauss, 2008; Lester, 1999; Moustakas, 1994; Smith, Flowers, & Larkin, 2009). Second, personal knowledge and subjectivity create the epistemological

paradigm within which phenomenological approaches are based. As such, they are can be extremely powerful tools in gaining insight into individuals' motivations and actions and in understanding subjective experience (Lester, 1999). Third, much like other qualitative approaches such as ethnography, field research, grounded theory, or hermeneutics, phenomenological research, in its purest form, seeks to start from a perspective that is free of hypotheses or preconceptions, and to describe, rather than to explain (Husserl, 1970; Smith, Flowers, & Larkin, 2009; Walsh et al., 2015). It is this philosophy that enables phenomenological methods to effectively challenge structural or normative assumptions through examining the experiences and perceptions of individuals from their own perspectives (Denzin & Lincoln, 2000; Lester, 1999; Moutakas, 1994).

In conducting the phenomenological case review for Phase I, the individual case notes of all 24 study subjects were examined, coded, and analyzed. These 24 study subjects comprised the original sample for this study. The number of weekly individual therapy notes, available for review per study subject, varied in quantity and length, depending upon how often each subject attended therapy and upon how long they remained in the treatment setting. Many sample subjects completed their specified treatment stays which were 30, 60, or more than 90 days. Others left treatment early for various reasons. Some of these reasons included: using drugs or alcohol while in treatment (relapse), engaging in verbal or physical altercations with others in the treatment setting, or feeling unsafe in treatment because of threats or homophobic remarks made by others. In addition, the author closely analyzed his personal process notes, taken concurrently on each of these 24 cases, to add credibility and validity to the

results of the case review, and to increase the trustworthiness of the study overall (Guba, 1981; Patton, 1990; Yin, 2003).

While conducting this case review, the author examined the individual case and process notes of each of the 24 study subjects to identify commonalities and differences, such as shared and divergent beliefs and perceptions about self, family, religion, and sexuality, and shared and divergent lived experiences pertaining to identity development, sexual preferences, experience and behavior, and how each of these influenced each study subject's feelings and experience with substance abuse. Yin (2003) describes how multiple case reviews can be used to either, "(a) predict[s] similar results (a literal replication) or (b) predict[s] contrasting results but for predictable reasons (a theoretical replication)" (p. 47).

Phase II: Member Check Interview

As noted above, in Phase II of this study, member check interviews were going to be conducted with as many of the 24 case review subjects as possible. Because the cases included in the sample for this study were spontaneously gathered over a three and a half year period and because several years had passed between the time they participated in treatment and the time attempts were made to contact them, it was expected that certain sample study participants would have changed addresses, changed phone numbers, be incarcerated, homeless, or otherwise unreachable for participation in the member check interview. However, because none of them responded to telephone and mailed invitations to participate while Phase II was being conducted, a sample of six study subjects, meeting study inclusion criteria, was selected via snowball sampling.

In qualitative research, member check interviews, also known as respondent validation or informant feedback, are used by researchers to help improve the external validity, and transferability, applicability, credibility, and accuracy of a study (Lincoln & Guba, 1985; Flick, 2006; Corbin & Strauss, 2008). Member checking in qualitative studies can be done during or at the conclusion of the study to increase a given study's credibility and validity. In order to obtain open and honest responses to member check interview questions, the interviewer should strive to build rapport with the interviewee. In certain types of member check interviews, the researcher will summarize or restate study findings and then question the study participant, or interviewee, to determine accuracy (Flick, 2006; Strauss & Corbin, 2008).

The value in this kind of reflexive process is in allowing study participants to critically analyze the findings and to make any necessary changes. In this way, study participants either affirm that study findings reflect their views, feelings, and experiences, or that they do not. If study participants confirm the accuracy and completeness of the summary of findings presented to them, then the study is said to have credibility (Flick, 2006; Patton, 1990; Strauss & Corbin, 2008; Yin, 2003).

In preparation for the member check interview in Phase II of this study, attempts were made to contact each case review study subject by telephone and/or by mail. When successfully contacted by telephone, each potential interviewee was invited to participate in this study with the IRB approved telephone recruitment script (Appendix A). If unreachable by phone, potential member check interviewees were mailed a study recruitment letter inviting them to participate in this study (Appendix B). Both the telephone recruitment script and study recruitment letter were carefully worded to protect

potential study participants' privacy and confidentiality. In addition, study recruitment letters were mailed to potential member check interviewees in unmarked envelopes to further respect their personal privacy and further protect their confidentiality.

Analysis of Data

Theoretical Sampling

To conduct this phenomenological case review in Phase I of this study, the author closely examined the individual case notes of all 24 study participants that comprised the sample of this study. As an important part of this process, the author examined the individual case and process notes of each of the 24 study subjects to identify commonalities and differences, shared and divergent beliefs and perceptions about self, family, religion, and sexuality, and shared and divergent lived experiences pertaining to identity development, sexual preference(s), experience(s) and behavior, and how each of these influenced each study subject's feelings and experience(s) with substance abuse. Yin (2003) describes how multiple case reviews can be used to either, "(a) predict[s] similar results (a literal replication) or (b) predict[s] contrasting results but for predictable reasons (a theoretical replication)" (p. 47).

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Open Coding

Open coding was used to identify themes and categories. This involved a line-by-line, micro-analytic process of identifying like concepts and their common attributes and properties within study data. The analysis of the data generated from this study was begun with open coding and followed a constant comparison approach to the development of grounded theory (Strauss & Corbin, 1998; Walsh et al., 2015). As the author engaged in the case review, reviewing each study subject's demographic information along with their individual therapy and process notes, certain kinds of information began to emerge, gradually forming repetitive patterns and themes. As the analysis continued, these themes were grouped into categories that began to answer this study's primary research questions. Strauss and Corbin (1998) call the process of open coding the "opening up of the data" (p. 61-74).

Memo Writing

Memo writing took place throughout the research process and was used to shift the analysis from a simple examination of the data to conceptualizing. Memo writing served as a link between the author's preliminary coding processes and the completed analysis. In addition, memo writing gave the author confidence in his ability to analyze and examine the study data by aiding in the process of identifying themes and commonalities emerging from the data, setting an analytic course, helping to create and refine categories, and in identifying the relationships between categories (Charmaz, 2000; Walsh et al., 2015). To illustrate, in the preliminary analysis of this study, memo writing helped to identify shared personal characteristics and the treatment experience of possible study participants that later served as a basis for the creation of this study's sample. Memo writing links a study's analytic interpretation with its conceptual and theoretical frameworks. By pulling the raw data together in this way, this process made it possible for the author to develop comparisons and ideas, to analyze categorical properties, and to identify patterns (Charmaz, 2000; Walsh et al., 2015).

Theory Building

The last step of the analysis for this study involved the creation of links between categories or phenomena, re-naming or re-labeling them as needed, and then reconstructing and re-visioning the data in new ways to develop theory. At this stage, the author constructed new theory by piecing together the themes and categories generated from both the case review and member check interview data, with the goal of explaining and predicting events so that this theory could serve as a guide to action, and provide

helpful insights and increase understanding into the substance abuse experience of men who have sex with men. This final phase of the analysis was considered completed or "saturated" when new information ceased to emerge during the coding process and when there was apparent agreement between coding data across the established categories (Charmaz, 2000; Strauss & Corbin, 1998; Walsh et al., 2015).

Procedures

The phenomenological case review conducted for Phase I of this study yielded a large amount of data pertaining to these study subjects' individual and collective substance abuse treatment experience(s). As outlined in the methods section of this study, the case review data was gathered and analyzed using the processes of theoretical sampling, open coding, and memo writing. The author met with each study subject for individual therapy sessions usually once or twice a week during their substance abuse treatment experience. The total quantity of sessions per subject varied widely across the sample, as each study participant began and finished treatment at differing times, stayed in treatment for differing lengths of time, and sometimes had to miss therapy sessions for other reasons.

None of the study subjects were coerced into taking part in individual therapy. During their orientation and intake processes, clients at the facility were informed that meeting with a therapist was one option, among several they could choose to participate in, if desired. The majority of study participants sought out individual therapy voluntarily, while a subset were referred by substance abuse counselors or by the program director, as the result of something that came up for the subject(s) during a one-

on-one meeting, such as a serious trauma or comorbid mental health disorder. Because the majority of participants sought out therapy on their own, the author often experienced an attitude of openness during these therapy sessions.

The author employed an eclectic therapeutic approach while working with study subjects in therapy, drawing upon elements of Cognitive Behavioral Therapy, a behavioral therapy originally designed specifically to prevent alcoholic relapse (Carrol & Onken, 2005); Narrative Therapy, which allows clients to re-author personal narratives highlighting strengths and externalizing barriers to success and happiness (Corey, 2013); and Solution-Focused Therapy, where the focus is on creating solutions to problematic behavior patterns, instead of focusing on their underlying causes (Corey, 2013). The author attributed some positive treatment outcomes to this eclectic approach because each invited the client's collaboration in the creation and application of sober living skills and new possibilities.

Self of Researcher

Although I applied my very best efforts to become a "participant" observer (Bolton, 1995; Kaminsky, 2004) in the substance abuse treatment settings where I conducted the therapy sessions with the 24 men that later constituted the sample for this research study, I am aware that my personal beliefs, perceptions, understandings, and biases influenced my effectiveness and ability to do so. These same personal qualities and attributes, however changeable and fluid over the years of this study (2008-2011; 2017), colored my perspective and understanding of the substance abuse treatment experience(s) of these study participants while they were having them in treatment. Also,

I found that to be the case while interacting with those subjects who participated in the member check interviews. This set of qualities and attributes influenced my understanding and interpretation of the data that emerged during both Phase I and Phase II of the analysis.

In light of this reality, and in an effort to strengthen the study's credibility and validity, I would like to acknowledge some of these that I feel contribute to my level of "participant observership" across various phases of this study. First, I am a Caucasian male who grew up in a large, conservative, religious middle-class family, and I am pursuing a doctoral degree in marital and family therapy. Second, having officially come out to family and friends, I identify as a member of the LGBT community; this was something that I chose to reveal with great discretion to a only a few study subjects during their individual work with me, when it seemed like doing so would be helpful to them. I feel that it is important to note here that, while I did not openly inform clients and staff members of my sexual orientation while working in the facilities where I was conducting the therapy work used for this study, I believe I was perceived as a "safe" male, or as someone sample subjects felt they could be open with, without fear of being judged, ridiculed, or criticized. Third, as a clinician learning about and working with substance abuse issues while in practice at this facility, I attended several different heteronormative and LGBTQ meetings for Alcoholics Anonymous and Narcotics Anonymous for a specified period of time, and as such understand on a personal level what it feels like to attend each as a gay man.

CHAPTER FIVE

FINDINGS

Phase I Analysis: Case Review Findings

The objective of Phase I was two-fold. First, I wanted to better understand what it was like for men who have sex with men to participate in a residential substance abuse treatment program where they did not necessarily feel free to disclose their sexual orientation, sexual experiences, or their sexual feelings. Second, I was interested to learn about how participating in substance abuse treatment in this kind of environment influenced both their treatment experience and their ability to remain abstinent from drugs and alcohol post treatment. The guiding research question for this study was: What is the experience of men who have sex with men in substance abuse treatment and recovery? Sub-questions included: a) How does withholding important information about one's sexual identity impact the quality of their substance abuse treatment experience? b) How does disclosure of one's sexual activities and sexual experiences while in treatment affect treatment experience? c) How may disclosing or choosing not to disclose one's sexual activities and preferences while in treatment influence their ability to remain abstinent from drugs and alcohol after treatment?

The case review data will be presented here on a temporal continuum that describes case review participants' substance abuse treatment experience. This will include their individual and collective impressions of the treatment they received, perceptions and evaluation of treatment staff, their description of the relationships they formed with others in the treatment setting. In addition, the case review data will be

presented here according to emergent themes that study subjects expressed contributed to or detracted from their ability to be open about their past sexual experiences or activities.

Question 1: What Did Men Who Had Sex With Men Experience in Substance Abuse Treatment?

Fear

Two kinds of fear were described by the 24 men in treatment. One fear was the concern that their treatment experience would be negatively influenced by other group members once they revealed their same sex activities. It was very common for men to describe offering sex to other men who provided them with drugs, or allowing other men to perform sexual acts with them in exchange for money for drugs. These men did not think of themselves as gay, but were using sexual behavior to avail themselves of drugs. All of the case review subjects who identified as heterosexual, tried very hard to make sense of this same-sex behavior that seemed confusing to them as they became sober. Some had an awareness that these experiences outside of the norm needed to be divulged in order to recover, according to some treatment group leaders. In the treatment setting, men would be directed to the group to share their concerns about the meaning of their sexual behavior while using drugs. "You're only as sick as your secrets" (AAWSI, 2002), is frequently stated to men in 12-steps treatment groups, with the understanding that being able to be open and honest about things that contributed to their substance abuse helps to solidify the foundation for long-term sobriety. Indeed, some men did share their experiences in this way and found that the response they anticipated did not occur. Some were accepted and supported. Others however, found that their fears were well-founded

when they heard disparaging expletives and threatening, homophobic threats and remarks in response to things they decided to share. Some reported being bullied by treatment staff and fellow residents. During smoke breaks, some were verbally harassed. There would be physical posturing by former prison inmates and gang members that intimidated some men who had divulged their previous sexual behaviors. This reinforced the men's fears and secrecy, leading a few men to leave treatment before completing their programs, and confirming their preconceived ideas about why they dared not share their personal sexual history.

The second type of fear was one that involved men trying to come to terms with their past sexual behavior while under the influence and its implications for their current relationships. Sample subjects were frequently tearful as they expressed their fear that when they divulged their past sexual behavior to their wives or girlfriends, they would be horrified, hurt, and rejecting. Additionally, these men who identified as heterosexual were shocked and anxious about what their sexual behavior with men meant or that they could even enjoy behavior that when sober, was repugnant to them. For example, one man described a group sexual encounter in a setting that included numerous men and women. After snorting a few lines of methamphetamine, he found himself much more interested in observing men having sex with men, than he was in observing or participating in sex with any of the multiple women present. He later realized that he had truly enjoyed this experience but couldn't come to terms with what it meant about his sexual identity.

Fear was mitigated for six men by their sense of pride that sex with men was an expression of their sexual orientation, and reported being proud of their sexual conquests.

It was typical for such men to brag about their sexual prowess in session. These men had already come out to family and friends. Usually these men were of adequate physical size that they could defend themselves. Because they were accustomed to defending themselves, they could hold their own if pushed around in bars or clubs. Many in this category were bold and felt empowered due to the positive feedback they received from both men and women throughout their lives.

When sample subjects expressed these fears in therapy, they were encouraged, by this author, to take their concerns to group. However, this invitation was met with numerous excuses about why they could not express themselves openly about these issues with anyone else. Nearly half of sample subjects had anxiety and mood disorders. Many of them tended to catastrophize about what would result if they talked openly with others about their concerns. They felt that one-on-one time with the therapist provided the opportunity to explore their secrets and they hoped that this would suffice, and prevent them from having to risk harm, ridicule, or judgement from other group members.

Acceptance of Sexual Identity or Behaviors

A subset of the sample came into the treatment facility as openly gay. They may have had longstanding relationships with men and had accepted their sexual orientation. The families of many of these men had accepted them and the lives they led with their significant others. However, when they came into contact with drugs, they had become addicted. These men came to treatment solely because of their inability to manage drug addiction, and not because their sexual identity or behavior was the cause of their drug

use. These men tended to "test the waters" with group and treatment staff members to see if they could accept them as gay men. The level of acceptance that these openly gay men received from others in the treatment facility varied widely and could change according to the practitioner or other group members participating in the treatment program at any given time. Some of the comments and nonverbal behaviors of treatment staff members seemed to resurrect these gay men's internalized homophobia that they had processed years prior.

One man assumed that the drug and alcohol counselors at the facility would be accepting and supporting of him, as he did not try to conceal his sexual orientation. Staff members had received sensitivity training around sexual orientation issues. This man noted eye-rolling and dismissive body language when he shared that he was gay. He reported that this lack of acceptance was distressing to him and he felt that it threatened to interfere with the efficacy of his treatment. He expressed his anger about having to stay in a facility where he couldn't be accepted. He was referred to a gay drug and alcohol counselor and was able to make rapid strides in treatment afterward. Clearly, one's own acceptance of sexual behavior, and the acceptance of staff and other group members, was critical for his successful recovery.

Feelings of Resentment

More than half of the sample, who identified as heterosexual, were resentful that they couldn't be the heterosexual men they hoped they could be. Drugs and alcohol had become a vehicle for them to express same-sex fantasies and behaviors that, at other times, they would feel unappealing. They were frustrated that they were disinhibited

when under the influence with a certain degree of comfort and confidence. When they were sober, many were very upset that they had to struggle with their same-sex feelings, the overtures that other men had made to them, and their own part in encouraging sexual behavior with men. One man said, "If it were humanly possible for me to stay high indefinitely, being with men wouldn't be a problem." It was only when he wasn't high that he found his same-sex behavior inconsistent with the sexual sense of self that he had fostered his whole life. He now felt ashamed and embarrassed. He was resentful of heterosexual men who were married and had children, and did not struggle with their sexual identity and behavior. Such men may have not had children, or had lost contact with their children due to time in prison and drug abuse. Several of these men expressed that they would have an easier time getting clean if they did not have to deal with their strained relationships due to their sexual behavior. Comparing their fractured and deceitful relationship foundations with their wives and girlfriends with relationships of heterosexual men in monogamous marriages lead to considerable distress and resentment. It was difficult for some to know if they should try to make amends with those whom they had harmed through their addictions because doing so would require them to discuss having had sex with men, and that could harm the women in their lives. This protection of their wives and girlfriends later became justification to avoid transparency and enabled continued secretive same-sex behavior with relapse.

Paucity of Language to Describe Who They Are

This was a very common issue both in therapy and in groups, by sample subjects' report. Society uses binary language to describe gay vs. straight, or bisexual. However,

this was not helpful for men who only indulged in same-sex behavior while high, but felt disgusted by same-sex behavior when they were sober. Some reported enjoying role playing with men, or participating in specific sexual activities with men while disinhibited due to drugs. They were more willing to be sexually submissive and to be aggressive or adventurous while under the influence. Those who injected methamphetamine, for example, were immediately sexually attracted to and active with whomever was nearest them. The mutually enjoyable experiences they engaged in while under the influence were also confusing and sometimes without name. However, they considered these behaviors to be unspeakable in an all-male group. When the terms *pansexual* or *polyamorous* were presented to these men in therapy, they were curious about this. Others expressed that they felt comforted that this was an identifiable set of proclivities according to researchers, even though they were frighteningly unfamiliar. Their reactions to explorations of their sexual actions ranged from loathing to full acceptance, and this was highly dependent on whether or not they were high during the experience.

Early Dismissal and Leaving Treatment

Some men who were mandated to residential treatment tried to get through the program by having friends bring contraband drugs and alcohol for their use to the facility. These men had no intention of participating in their own recovery. Some were trying to gain custody of, or contact with their children again, by going into treatment. Others had chosen to attend rehabilitation instead of going to prison for drug-related crimes. Some were instigators of conflict in groups and others became violent toward men who had

divulged same-sex activity. These men were asked to leave as such behavior was not tolerated in the facility. Some men who experienced harassment from other residents due to their sexual behaviors used this as an excuse to leave treatment. A few men could not cope with their perceptions of being judged or being made to feel unwelcome due to their sharing of sexual activity with men. They had been able to tell the counselor and therapist about their sexual behavior, but some felt exposed and anxious and decided it would be easier to leave. They left the facility and said they would find their own way to recovery, some with their ride away from the facility offering them drugs in the car. Of the 24 men in Phase I, 25 percent were discharged early because of these kinds of issues.

Outcomes for Those Who Divulged

As stated earlier, 12 men were able to discuss their sexual identity or experiences with the group. Of these men, six were openly gay, of which four were in established partnerships. These partnered men expressed hope that their partners would stop using drugs, as they had often used drugs together as a couple. These did not involve their partners in treatment, and none of these partners came to the facility for visits. The gay men thought that their partners were still using drugs, which caused them worry and consternation. One gay man referred to his husband as his wife repeatedly while in the presence of others. When he eventually told the other residents that he was married to a man, he was the recipient of physical violence and verbal abuse. This resulted in his discharge from treatment because he responded with violence to the bullying.

One man, who had been living with his parents, had a history of stealing from them, bringing men home when they were not there, and violated every stipulation they

gave him for staying in their home. He had consistently denied being gay or having an interest in men, although they had inquired about his sexual orientation several times. As he was able to come out to the therapist and his larger treatment group, he participated in a phone call with his parents, in which he took responsibility for the wrongs he had done. He came out to his parents and was able to apologize and openly share with them who he truly was. This was both moving and the beginning of a healing process for him. Unfortunately, he did leave the facility early and did not complete treatment during that episode.

Six of the men who divulged their same-sex activities identified as heterosexual. Four of these men had a somewhat positive experience discussing their sexuality with the therapist and in their group. It became clear to them that they needed to do some kind of repair work with their wives, girlfriends, and parents. They had been questioned by these individuals about the nature of their relationship with men with whom they had sex in the context of using drugs. These men invited their girlfriends and wives to participate in couples therapy with the therapist. Most of these women had difficulty getting either time off from work or child care, so therapy consisted of only one or two sessions. The purpose of these sessions was for the men to make amends and offer an apology for their infidelity and for intentionally misleading their partners regarding the nature of their relationship with other men. This was one method for putting the principles of the 12-step process to work. Women were then able to indicate whether or not they could accept and work on the relationship with him. These kinds of sessions were left unresolved in most cases, to allow the woman to make a choice about starting over with her partner in light of this new information. All of these four men received some degree of positive

response from their partner, even though the women were very angry that they had been placed at risk for sexually transmitted diseases. All of the women had some existing suspicion and hypotheses about the sexual activities of their partner and there had been mutual collusion by both in denying the reality of these relationships. They expressed their outrage, went home and reevaluated the possibility of rebuilding the relationship. For the most part, they were conciliatory and supported these men to continue their treatment, making this anxiety ridden experience worthwhile in the long run. Having the support of their partners and ongoing support of treatment staff allowed all four of these men to finish their programs.

All of the men who were able to discuss their past sexual history with significant others seemed to find a new level of authenticity as they learned what it meant to be an honest person. Making amends and asking forgiveness provided a sense of confidence, solidarity with those on their sobriety team, and instilled hope that they could eventually live a successful life free of drugs and alcohol. They described that they received more from treatment than they thought was possible after being able to explore themselves more fully and to accept who they were, and what they had done, without judgment.

Unexpected Findings

Some of the men explained that their preconceived notions about being rejected because of their sexual past were proven untrue. Some men were met with support and acceptance, and others applauded for having the courage to share and to become vulnerable. These unexpected reactions, in the face of their castrophizing about rejection, helped them to feel more secure in discussing their concerns and in overcoming the

shame and secrecy that threatened their sobriety. They were able to discuss the implications of their sexuality and perceptions of their sense of self. This also helped gay and non-gay residents in the group, as they had the experience of interacting with a gay person in a positive manner. Some heterosexual men confided in therapy that they felt empathy for the loss of parental support that some of the gay men expressed during group. They had never had to face the loss of parental relationships and could not imagine attempting to become clean and sober without family support. Several heterosexual men revealed that they had had limited or no contact with gay men prior to treatment, and were therefore quite homophobic. They reported that their ideas and opinions began to change when they heard the courageous stories and participation of men who had sex with men. Both gay and non-gay men expressed surprise that sharing this information in a protected setting was healing, for all involved, and pointed out the commonalities they shared as men in treatment attempting to get clean, rather than focusing on perceived or real differences.

Another unexpected finding was that those men, who were willing to process the meaning and impact of their sexual experiences, began to realize that it was not necessary to define themselves by their sexual acts. They seemed quite surprised and relieved to learn that some of these behaviors could have been symptoms of their addiction that had been reinforced with the euphoric mind change of being under the influence. Others with mental illness, such as bipolar disorder or delusions, began to realize the impact of drugs on their creativity, energy, sexual behavior, and vivid hallucinations. Some felt the freedom in therapy to discuss what it might mean to be gay or how they could express their sexuality in a non-stigmatizing, positive way. Five sample subjects were able to

adequately assimilate this new information into a sense of self and to understand how it contributed to their addiction processes.

Question 2: How Do Men Do in Treatment if They Withhold Their Sexual Practices or Identity?

Twelve men chose not to discuss their sexual practices in the group. However, several brought up these topics with their drug and alcohol counselor or therapist. Some chose not to share their sexual issues during 12-step groups at the facility, but it is unknown how many divulged their behaviors in outside groups they attended during the course of treatment. The following themes represent those study subjects who raised concerns with the therapist about sharing their sexual behavior during group. Some of the remaining 12 participants did go on to later discuss these in the group setting, after they initially received a positive response from the therapist. The themes below emerged from commentary in therapy from those who opted to share in group and those who chose not to.

Denial and Minimization

Denial can be used as a verb, a process, or a state of mind. Some men in treatment divulged same-sex behavior and attraction while using drugs. A subset of these men left treatment at varying times during their treatment episodes, and when they later returned after relapse, they denied ever having participated in any same-sex activity, even though they had previously disclosed it. Some of them had formed relationships with women, while they were away, in order to survive financially and socially. These men

hotly denied that they had ever had sex with men and were indignant when they were reminded about their previous comments in therapy about sex with men.

Another subset of sample subjects had been molested by other men when they were young boys and reported that they returned to familiarity of same-sex behavior when under the influence of drugs and alcohol. A few of these men had divulged this to a parent who berated them and threatened that if they were gay they would be kicked out of the house. Being gay or ever engaging in sex with men was a very negative specter to some of these men, and they therefore denied it or the emotional impact that it could have had on them. Others were fearful that their wives would leave them if they learned that they had participated in sex with men and put a lot of effort to create and maintain an identity as men not at all interested in other men.

Many study subjects, who had been molested, reported experiencing intense physical pleasure along with high levels of fear during each episode. As they got older and developed the ability to contextualize what they had been through as children, they described their adult activities with other men as "exhilarating" as they had experienced this same forbidden sexual contact. During these same-sex activities, that these men typically only engaged in while high, led the them to disconnect from this as they "turned over a new leaf" in sobriety with seemingly moral choices. For study subjects identifying as heterosexual, this meant starting over, making heteronormative, socially- accepted decisions with regard to sexuality and relationships.

Men who shared about being sexually molested, often asked the therapist about whether or not they needed to discuss childhood molestation in the larger group setting, if there was a perceived connection between molestation and their adult same-sex activity.

However, more often than not, the men reported that they had opted not to discuss their sexual abuse and the trauma associated with it during group.

Some study subjects chose not to address any sexual issues during their treatment, preferring to be treated as "one of the guys." They did not want to stand out as a gay group member, or as someone whose sexual behavior prevented them from fitting in with others. They wanted to move through treatment and get sober without exploring these painful issues. However, these men were still very worried about whether or not this was a healthy decision, in view of the potential these secrets could have to lead them to relapse in the future. Their desire to be able to get along with fellow clients, or to engage in sports and other all-male activities, outweighed any potential benefit of working on their issue of sexual ambiguity. They therefore only occasionally spoke in therapy about their same-sex behavior, and chose to compartmentalize these experiences, hoping that it would not lead them to self-destructive behaviors in the future. In this way, they remained an "inauthentic self" during treatment, and perceived that this may have impacted their overall success in treatment.

As men were coming down off drugs, they were offered confidentiality in their first therapy sessions. It was very common for these men to tearfully express numerous sexual experiences, molestations, and promiscuous activities with men that they felt were deviant. These narratives would be explored and concerns were validated in the privacy of the therapy room. However, many of these men would return for their next session and insist that notes about these matters be removed from their chart, expressing concerns that their secrets not be divulged in any way outside the therapy office. They would subsequently minimize their prior tearfulness and the intensity with which they may have

expressed about their sexual experiences. Others simply refused to ever discuss it again. It appeared that one reason for this denial was fear of the pain and unknown path before them, if they were to further explore the meaning of their sexual dalliances.

One study subject identified himself to the therapist as a sexually active gay man. However, he had wished to explore the possibility of having a relationship with a woman. In his later marriages, during which he fathered children, he reported denying ever having any sexual feelings or experiences with men as well as ever using drugs to enhance his sexual performance. He appeared to be very sincere and seemed to be the average next-door-neighbor kind of guy. He reported that his marriages ended due to his frequent episodes of infidelity and relapse. Much of his promiscuity was fueled by returning to drug use.

When men denied their propensity for drug use or same-sex behavior, they eventually seemed to believe their stories that they were not interested in other men or drugs. When these were divulged in therapy, they were forthcoming, vulnerable, and emotional. However, in subsequent sessions they would behave as if these prior discussions had never had taken place. This presented a continual challenge to the therapist who recognized the strong association between study subjects' drug use and their sexual behaviors.

Lack of Transparency

This treatment program was based on the Twelve-Step Model that encourages a confessional approach to being transparent about wrongs to self and others as a foundation to recovery. Those who withheld information or chose not to divulge

particular sexual concerns stated that they were worried that their recovery could not be secure because of the secrecy and shame. Group facilitators often encouraged group members to be honest in their discussions as a way to free themselves and focus on recovery. Many men questioned the therapist about whether or not they should be fully transparent with the group, fearing that the group response would be negative. They felt trapped between their fears of vulnerability and fear of failing in treatment. In a heteronormative milieu, some were quite concerned about discussing homoerotic feelings and events. They did not feel they were "working an honest program" and were worried that they would relapse if they did not gain the full support of the other group members. Those who chose not to raise issues of sexuality in the group decided that the potential for their significant other and other men in the group to reject them outweighed the benefit they could receive by discussing these concerns. Some cited societal expectations of men who could engage in illicit behaviors as long as their significant other and the larger society did not penalize them for it.

Self-Doubt, Worry, and Confusion about Self

Most of the men discussed their concerns in therapy that their sexual behavior before sobriety could affect their future. Some expressed a sense of panic that they could be gay and since they did not have a group to discuss this with, their anxiety was heightened. Lack of a reality check with others, and their own ruminations led to concerns that they could be living a lie if they were truly gay, or simply a heterosexual who had "behaved badly." They recognized that they had positive sexual experiences with their wives, but also felt some satisfaction recounting sex with men. This confusion

led some to divulge more than they felt they should in therapy. A few men returned to therapy the next session after discussing their sexual confusion and actively sought validation and reassurance that they were acceptable as individuals. Others never mentioned it again. Some wondered aloud if they should even be in treatment if they couldn't discuss the meaning of their sexual behavior in a group setting, feeling that they were not strong enough to face the implications of their behavior.

One man had a long-term same sex relationship with a cellmate in prison. He also had a girlfriend before being incarcerated. He was remanded to residential treatment and had not disclosed the nature of his relationship with his cellmate to his girlfriend. He was very concerned that he had stronger feelings of attraction for the man than he did for his girlfriend and wondered if this was merely due to the sexual release he experienced, or if he really loved this man. He did not want his girlfriend to visit him in treatment because he was longing for his male companion and not the woman. This confusion predominated therapy sessions and he could not come to terms with his sexuality. He eventually left the treatment facility and relapsed. This man's agony and confusion was typical of those who struggled to understand themselves within the confines of their own minds.

Fear of Being Discovered, Ridiculed, Judged, or Assaulted

The 12 men who chose not to discuss their sexuality with anyone but their therapist, had a legitimate fear that if they disclosed to the group, they would be judged or physically assaulted. Sadly, this did occur in this facility when a couple men attacked one individual who had divulged his sexual behavior. Staff members who witnessed this attack only saw the man defending himself against the bullying men, and was sent from

the treatment center for his assaultive behavior. Men in therapy cited this experience as a strong deterrent to them being transparent in groups about their sexual behavior. Such men did not feel close to the other men in the group and could not benefit fully from the group dynamic. They reported that they kept these men at a distance to avoid being questioned or found out. They also reported that some very masculine group members would brag about their physical and sexual desirability to other men, but expressed disdain for men who did have sex with men. Their disparaging comments about men who had sex with men discouraged them from being transparent with their sexual concerns. Interestingly enough, a number of the ultra-masculine men who were referenced, would not discuss their own painful history of gang involvement or sexual molestation when they were children because they were fearful of feeling vulnerable.

Increased Homophobia and Loss of Hope

In the course of offering therapy for these 24 men, it became apparent that discussing sex with men aroused a sense of negativity about sex with men. This was sometimes due to being victimized on the street by other men, or feeling disgusted that they had engaged in this behavior only when high. Depressed feelings resulted as they considered how they had lost their executive functioning when high and had exercised poor judgment in engaging with men whose character was less than stellar. Some described feeling like "losers," or "fools." As they told these stories of their behavior they began to feel more negative about sex with men, leading to their embracing a more homophobic stance. This same sex activity had been conducted in the context of lost relationships, criminal activity, and victimization. Some were overwhelmed by

recounting these issues and simply decided that it was too painful, too much, and too risky to continue.

One young handsome man realized that gay men would find him attractive and allowed them to perform sexual acts on him in order to obtain money for drugs. This form of "hustling," included stealing money from these men's wallets or taking money when the men were unaware. A number of men told about exploits to obtain drug money at any cost, which later left them with a strong sense of self-loathing and regret that they had engaged in sex under false pretenses. This fed both his cognitive dissonance about the lack of morals he had while high, homophobic feelings, and loss of hope that he could ever overcome his past.

Interpersonal Barriers and Isolation

The secrecy of men who were fearful of divulging their behavior prevented men from fully participating in group activities and informal opportunities to share with other residents. Those who were able to be transparent in the groups expressed to the therapist that they had a renewal of faith in a higher power, that they could see changes in themselves, and were grateful for a newfound sense of freedom that they had by relieving themselves of the burden of their confusing sexual behaviors. Those who did not share reported that they had not been able to build relationships on shared experiences, or trust others sufficiently to benefit from the support of group members whose feedback could have shown these men that they were not alone. They reflected in therapy that they wished they could get this level of support but felt isolated from their roommates and staff. If the therapist missed an appointment due to illness, such men were furious with

him because all of their support came from the therapist and in their minds, was the only safe haven to discuss their concerns. This set them up for failure since they held group members away from themselves and were never fully able to explore the secrets of their past.

Cognitive Dissonance, Treatment Failure, and Relapse

A number of issues contributed to a sense of confusion and cognitive dissonance in the men who maintained secrecy about their sexual concerns. They expressed religious beliefs, societal expectations, family proscriptions, and desire for family, as opposing the positive same sex encounters they had so enjoyed. Some described themselves as "an abomination," "feeling unworthy," "sinful," and objectionable in God's sight. They wondered aloud how they could complete steps four and five of the 12 steps, (acknowledge moral failings and confess them to another human being), when they felt immoral and incapable of being open about what they had engaged in. The openness, vulnerability, trust, and healing through confession that formed the backbone of the 12 step program, could not be appreciated by these men who were fearful of discussing sexual behavior openly. Some, who had been remanded to therapy and were using their job's insurance, decided that it would be a waste of their employer's money to engage in a program that they would not utilize fully. Some did not believe in a higher power and others did were disappointed that so much transparency was required in order to achieve sobriety. These individuals often chose to leave treatment as the cognitive dissonance and emotional cost were too high.

Phase II Analysis: Confirmatory Analysis

For phase II of the analysis for this study attempts were made by telephone and by mail to contact all 24 sample members. As predicted, this process proved difficult. Many participants' telephone numbers and addresses had changed since participating in treatment. Some participants' cell numbers were no longer active or valid, or participants had given the contact number of parents or significant others who did not pass along phone messages or letters containing the invitation to participate. Because none of the individuals represented in the case review responded to invitations, calls, and messages left, a snowball method was used to recruit six individuals who had participated in other treatment programs to determine whether their experiences supported the case review findings.

These six member check interviews took place in February and March of 2017. Half of the interviews were conducted in a local church library, two took place in restaurant locations near those participants' homes, and one took place in a local coffee shop. The interviews ranged from 45 to 90 minutes in length. After making initial contact, almost half of the 6 interviewees cancelled their original interview appointments and needed to be rescheduled after confirming their willingness to participate. Each of the interviewees that completed the member check were given a $25.00 gift card for their participation.

The member check interview was designed with nine main questions, divided into two sections: *background*, inquiring about the subject's overall experience in treatment and *extension of case review*, (see Appendix D) containing questions designed to validate and confirm the information generated by the case review. Each of the nine questions

contained several prompts as needed to take subjects deeper or to obtain additional information about a specific topic or response. Those themes that validate or confirm those present in the case review will be presented first, followed by exceptions and commentary, observations, and field note analysis.

All six of the participants identified as gay at the time of the interviews. Four had been forthright about their sexual orientation during treatment, and two had chosen not to discuss their sexuality even though they had come out to family and friends prior to treatment. Three participants completed the treatment program and three had not completed it. Five had remained sober after the treatment described in the case reports above and one had relapsed and recovered. Three of the men were former methamphetamine abusers and three were recovering alcoholics. One participant was African American, two were Hispanic, and three were Caucasian. They had been in recovery from three months to 18 years. Five were single and one was married to his husband. Some of the questions were adjusted to the population of the interviewees since none of them had attended the treatment facility represented by the case reviews above.

Question 1: What is the Experience of Men Who Have Sex with Men in Substance Abuse Treatment and Recovery?

Because all member check interviewees self-identified as gay, the concerns and experiences they shared regarding perceptions and treatment experiences were different than those who identified as heterosexual in the case reviews. However, because all member check interviews were male, there were many parallels and supporting evidences

that men had similar concerns about maleness and masculinity, and the socialized processes associated with failing to live up to what that means to each of them.

Fear

Four of the six interviewees described feelings of fear when discussing residential and outpatient treatment experiences. Just as the heterosexual men in the case reviews had fears and heightened sensitivity about addressing sexuality and sexual behaviors in all-male settings, gay men also seemed concerned about sexual transparency because they felt that becoming vulnerable in the presence of male peers was something they wished to avoid. One man stated, "I just have a hard time trusting men in general. Like they all want something from you. That's just how I felt." (SS6) This was a muscular tall bearded man with tattoos and would not readily be perceived as fearful about anything.

Two other men reported that they felt apprehensive about disclosing their sexual identity due to the knowledge they had about gay stereotypes of many people. "It was a little scary because you know, I was bullied…'here comes a faggot'…I was a little uncomfortable because I knew I was not welcome there." (SS2) Another man stated:

> Being that I was the only gay man there, I kind of felt like, I was uncomfortable opening up to certain people or in group sessions. I kind of felt like I was being talked about behind my back. You know, when you go from addiction to recovery, you already have a poor sense of self-esteem and paranoia, and self-confidence, and you worry about what others think about you (SS5)

These men were worried that they would be singled out because they were gay and would not be given the same respect as non-gay men in the groups.

Gay men reported that they and concerns about being "cruised" or "13-stepped" by other men in the recovery groups. These terms refer to a common 12-step occurrence

that happens in many support groups, in which predatorial advances are made toward the most vulnerable individuals in recovery. The more attractive and vulnerable the new group member is, the more frequently they would be 13-stepped, harassed, stalked, and exploited. One man stated, "It seemed kind of 'meat-markety' to me, so I was very untrusting." (SS6) Another explained his concerns when discussing the 13-stepping reception of other men he witnessed and experienced while attending meetings:

> You'd hear about men that would, you know, prey on newbies, you know, and welcome them but have ulterior motives. At first I was a little apprehensive about talking to some of the older men…so that was my first apprehension that I didn't want to intermingle with what I had been told were, oh, stay away from such-and-such because he's a perv and that's all he wants…my only trepidation at first, and I was cautious not to fully divulge any personal information about myself because I just didn't feel comfortable with that. I would only share my issues regarding my drinking only in front of them (SS4)

Clearly, these men did not feel completely safe or at ease in these groups, even when it was an LGBT group. As a result, three of the six interview participants chose to attend heteronormative group meetings because they felt they could focus more on staying sober and developing themselves. One participant reflected:

> My being gay wasn't the reason why I was an alcoholic, you know? It was a coming-out party. What I need is like a solution to my alcoholism, not a solution to being gay. I wasn't hearing what I needed to hear. It's too much drama… (SS6)

The participants reported that they were also fearful that their experiences and personal reflections in the group would not be respected or held in confidence, just as the participants in Phase I of the study. One participant described his concerns this way:

> I was afraid that if I shared personal information myself that people would not keep it private. I would go to another meeting and they would say, "Oh, I heard you were crying…" What?! …So I only shared certain things…When it came to me sharing about being raped as a child and as an adult, I could not share that at meetings. That was none of their business. If it would have stayed in the meeting I would have shared everything, what happened to me as a child, as an adult… (SS2)

This man chose to explore the rapes with his therapist because he felt safer with her and the pledge of confidentiality. Another endorsed the need for a therapist to tell things to that couldn't be told in a group:

> You can build a kind of relationship or rapport with your therapist. We just need someone to talk to. Um, [gay men] live our whole lives not being heard, and there's so much that we need to say….I was able to say those things without feeling that if I said something that I was gonna offend someone else around me. So it was more liberating for me (SS1)

The sexual orientation of the therapist or group facilitator seemed to be immaterial if the men felt safe and accepted by them:

> I do remember one counselor and being able to talk to him about everything. Although I believe he was a straight man, he seemed like he was able to normalize a gay relationship while talking to me…he never said things, "Well, I don't know how it is with you [gay] guys," but he was very understanding (SS5)

Two participants described the fears they witnessed in men who identified as heterosexual, pertaining to same sex activities while under the influence:

> So it was easy for me to say, yeah, I'm gay and it's not a big deal…I think for some of the other guys, especially the methamphetamine users to say, uh year, you know that really kind of messed me up a little bit because in the active use of that kind of dope you start to participate in like, lots of promiscuous situations, and um, a lot of those led them to homosexual activity. But they were uh, kind of afraid to say it. But once I opened up then all of a sudden, there was like five guys in the group said, "uh yea, I've been there, done that, and I'm ashamed of it and my wife doesn't know and I feel bad and I'm afraid I have AIDS." So it was not uncommon… (SS3)

Another man described attending a heterosexual support group and being called a "fag" when he arrived. When he was given the opportunity to speak to the group he recognized men he had had sex with at drug parties. He recalls telling the group:

> First of all, when we are all tweaking, you're all gay. You all jump to the other sex…because if we were at my house together tweaking you and I would be having sex. You could be as straight as they come—let's tweak a little bit. You don't care…all of you guys have been with a guy when you are high (SS2)

A man later thanked him for identifying himself as gay, and the participant reminded him that they had had sex before while high. Needless to say, group participants knew from then on not to criticize him because he knew and remembered their sexual interactions with him.

All of the interviewees confirmed that fear played a significant role in their treatment and recovery experiences. These fears included fear of being singled out for being different, fear of being perceived as vulnerable or less than masculine, fear of being judged or ridiculed, fear of sexual behavior being revealed or told to others, fear of being 13-stepped, and fear that what they share in group will not be held in confidence.

Acceptance

The six participants described acceptance in relation to how they looked, dressed, identified themselves sexually, their sexual experiences, and substance abuse histories. Because all of the interviewees were gay, being accepted by straight group members was a common concern. "For the most part, they were very accepting…and even sometimes joking about [my being gay]. But there was always a few of them that you know I wasn't very close to." (SS5). This variability in trust and acceptance based on sexual orientation was managed in various ways:

> The majority of the group was not LGBTQ…I talk about my life issues with the same kind of enthusiasm as someone that's …not LGBTQ talks about their life….it was kind of off-putting to some people….it was difficult to get the room to understand your perspective. [Our] struggles are basically the same struggles that every human being goes through…they talked a lot about heterosexual relationships and stuff, which you can't really identify with if you are LGBTQ…since we were the minority, our voices were not really heard (SS1)

Another reflected on the mixed response he received:

> Probably a fourth or less of the people [there] were not that comfortable with who I was because aside from being gay I was in the military. I don't look like, you know, some flaming Tinkerbelle or anything so I wasn't very offensive to them (SS3)

However, being a gay man in a group of straight men did feel somewhat anxiety provoking: "It's weird for me talking about a lot of my issues to straight men because I feel that level of resistance like I've got to mentally prepare myself before this guy shares with me." (SS6)

Two men reported that the group leaders and residential staff attempted to mitigate the effects of differences in sexual identification by openly stating that the purpose of the group is to address substance abuse issues, not sexual behavior or orientation. One man who had been in three different treatment facilities reflected that being accepted and being open was a process, validating the experiences of the men in Phase I of this study:

> …Sex and drugs were obviously a huge part of it and I did not feel comfortable talking that in the first group. It seemed like I was at odds often…that's when I was discharged after 30 days, because apparently, I was the problem…In the second one, I was starting to settle down more and more and I felt like my relationship with the other clients was good. I was still very much in the closet. Maybe I told a couple of trusted peers…the third one, I pretty much outed myself to the whole house and they were for the most part, very accepting and even sometimes joking about it… (SS5)

The more the men divulged in group, the more they saw others respond positively to them and their fears were contradicted. "I was not open at first, then became open about it, and after I did that I noticed that the guys that were in my group, that's when they began to say, 'Oh yeah, me too.'" (SS3)

Unlike the men in Phase I who identified as heterosexual and did not share their sexual experiences, the gay men who were interviewed could more openly discuss and

name their sexual behaviors. They perceived their sexual behaviors as a natural extension of their sexual orientation. The interviewees also seemed to find a connection between their own sexual histories and the sexual histories of men who identified as heterosexual. Their willingness to be open allowed heterosexual group members to clarify their authentic, non-substance enhanced sexual identities and to differentiate between themselves and gay men:

> There were some that were, "yeah, I don't agree with your lifestyle but it's okay for you…and then there were some guys who you could joke with rather openly. They seemed a bit curious as I began to disclose the type of activities that go on in gay lifestyle with the use of amphetamine. They were like, "oh, wow, really? That sounds interesting. I wish I would have done that before I got sober"…kind of like knock some things off your bucket list, I guess (SS3)

This participant's experience confirmed the reality of generalized male fear of sharing taboo sexual explorations, but that these things could be discussed in a safe environment. In addition, when they chose to disclose these experiences they discovered that seemingly non-accepting group members offered support and useful perspectives with which they could identify. The value of being able to share close connections with group members was described by this participant:

> I've made a close friendship with a few select people that um…I can share my true self with like you know, my deep dark secrets if you will, about my family, about who I'm dating…and they've been so good because they also understand the struggle of what it is to be in alcohol treatment as well (SS4)

The limits of friendship and the possible dangers of sticking close to group members one befriended, was powerfully illustrated by one participant:

> Acquaintances, not friends…you know, you're my friend during the meeting…you know, my compadre. But once we leave that meeting, you go your way and I go my way. Because one thing I noticed is that everybody there are friends with each other. Like the book says, "Change people, places, and things." I changed everything! I don't want to have friends who have dealt with drugs before. Because keeping the same drug having friends, you're bound to relapse.

> Once we leave the meeting we don't talk. And they tell me, "Why don't you wanna hang out? You're a felon?" "Yeah, I am." "We can't hang out, we'll violate our probation" (SS2)

Across the board, study participants in Phases I and II expressed a desire to be accepted by other group members in order to feel safe and be able to share their experiences. However, this desire was often thwarted due to preconceived ideas about the responses of others, their ability to understand or accept their sexual orientation, past behaviors, and current sexual identities.

Resentment

In Phase I, resentment was related to a perceived ability of heterosexual men to live up to the desired heterosexual ideal of marriage, family, respectability and "appropriate" sexual behavior. The interviewees reflected some of this resentment in that they as gay men could not obtain the same social status and approval by parents and others. One man, who had not come out to his family, had been his parents' caregiver through their final years. "The only reason I was using drugs was to keep…to have the energy to take care of them. I tried to kill myself twice…" (SS2) He was waiting for them to die before coming out, as he feared that their knowledge of his sexual orientation would be devastating to their relationship. He was resentful that he allowed his drug use, and the stress from trying to pass as straight to his parents, nearly cost him his life.

Another participant pointed out the need for heterosexual men to maintain an appearance of remaining heterosexual in groups by posturing as hyper masculine men. Rather than simply being open or approachable, the heterosexual men in one group created distance with the gay participant by "making a big deal" out of the fact that they

were friends with him, a gay man. It was offensive to the participant to seem to be such an outlier that it was a matter of comment that they could even be friends with him. This validated the behavior and attitudes of heterosexual men in Phase I, who seemed to need to be considered "one of the guys," but did not want to be identified in any way as having gay characteristics or experiences. They therefore connected with the gay men with some degree of fanfare, and in a way to differentiate themselves from gay men. As one participant stated that it was a, "methinks thou dost protest too much kind of situation." (SS3) The efforts at creating a distance between gay men and themselves further allowed them to deny that they were like men who had sex with men.

Denial

In Phase I, the study subjects manifested denial about their sexual identities and behaviors, the impact of past sexual abuse, and how they could have hurt other family members. An interview participant who began using drugs at age 14 reported that his stepfather had been murdered, and another parent had been a drug dealer. He minimized the impact of this life and hinted about possible victimization as a child that was never disclosed in the interview: "And so there was lots of weird activity, and probably traumatic activity, but I wasn't noticing it because to me it was just kind of normal." (SS3) Another participant explained his denial in this way: "Once you start denying one thing, later on it will eat you up inside and you will go back to using because you can't accept who you are… (SS2) This participant's comment supports data in Phase I that indicated that men who could not accept or address their past same sex activities and

other painful issues, left treatment prematurely and relapsed or engaged in relationships that helped them continue to deny this aspect of themselves.

Paucity of Language

The men who were interviewed were openly gay and had years of experience expressing themselves and talking about their sexual activities. They had no difficulty with language. This was in distinct contrast to the men in Phase I who had not dared to speak with anyone except the therapist about their sexual activities with men. These men scapegoated the effects of drugs as the reason they had sex with men, since their frenetic sexual explorations while under the influence were sometimes sensation-focused and often not verbalized.

Interpersonal Barriers and Isolation

One interviewee participated in three different treatment programs and only successfully completed one. He had achieved longstanding sobriety at the time of the interview. He did not like the stringent, controlled milieu of one, and did not feel prepared to address his issues in another. He reported, "I just felt like there was a lot inside that I needed to get out that I didn't feel comfortable getting out in a group setting." (SS5) He used his time with his therapist to address these issues and this kept him sober.

As noted above, some gay men did not initially feel welcome or comfortable in groups that were geared toward heterosexuals. However, half of the interviewees reported attending such groups because they felt they could focus on the recovery process

better there, instead of on gay centric elements of life that could be dealt with elsewhere. Two men chose to explore their sexual victimization issues with their therapist in lieu of bringing this to the group.

One participant cited his therapist as removing the barrier of self-loathing about his addiction by pointing out that he was not his addiction, but was a man with an addiction. This externalizing approach allowed him to address the addiction, still feel worthwhile, while simultaneously participating in his group. The participants expressed delight that they felt less isolated when they were able to share their experiences and needs. One participant explained his surprise when his sharing were met with support and empathy:

> I did feel understood because people, older people came up to me afterward and said, you know, I've gotten DUIs before and I know how you're feeling right now. I shared what I was going through with my church and how painful it was. A lot of men and women that were in those meetings would come up to me and say, "Hey, thanks for your story. I empathize with you. I understand what it feels like, because I've gone through that with my Catholic church or a pastor, or my family." So, I did feel understood (SS4)

Another man reflected on his time in residential treatment as a time of solidarity:

> …You learned to help other people and be a part of a social group and to care for individuals who care about you, and you got to cook for them, so it turned into all my personal needs being met… (SS3)

Men in Phases I and II spoke of their concerns about sharing, transparency, and acceptance. This experience yielded variable results. But the majority of men, who had the courage to allow themselves to be known, had positive outcomes.

Discharged/Left Treatment Early

Two of the interviewees reported that they had left treatment early. One

explained that his readiness to address his substance abuse issues, along with problematic relationships with staff and clients, were factors in his decision to leave treatment early. "I don't know if it was the staff or what, but I got about four or five months into it and I decided to leave. But I did stay clean after that one." (SS5) A second interviewee opted not to engage in residential treatment and had frequent relapses. However, he continued participated in outpatient groups between relapses. Eventually he saw the value of staying clean and remained clean to the time of the interview.

Interestingly, the interview participants, all of whom were gay, reported that they left treatment at varying points not only because of drug cravings, but largely due to the way they were made to feel unwelcome or not part of the larger group. It seemed that the participants in Phase I who were treated poorly after divulging their sexual identity, or had to address their painful pasts, also chose to leave because of being assaulted, marginalized, or exploited.

Withholding Sexual Identity

In Phase I, the men withheld information about their sexual experiences because they were socialized as men that same-sex attraction and activities are abhorrent. Many of them expressed feelings of shame and confusion about these actions and their possible ramifications. Therefore it is not surprising that they did not want to address something that they themselves had not resolved. The gay men who were interviewed, in contrast, had reached a point in their development where they had embraced their sexuality and knew that this was not the focus of their treatment attempts:

> We're here to address your substance abuse issues and whether you're a gay man or a straight man, you know…even though that's a big part of who I am, it was a small part of the issue at hand. The big part was my substance abuse (SS5)

In addition, withholding sexual identity and activity in groups raised concerns with the Phase I participants about whether or not they would benefit from their treatment groups, or "run a good program." Out of this fear, some of those men chose to withhold this information, and others chose to be open, not knowing what the outcome would be. None of the interview participants had withheld their identity in their group experiences. Although their decisions to be transparent sometimes had negative consequences, they chose not to hide who they were.

Exceptions or Unexpected Themes:

The six men who agreed to be interviewed had been able to maintain recovery, in spite of the interviewer's a priori assumptions that they were active in their addictions. Society considers men in recovery as never fully recovering or being worthwhile citizens. These men had worked very hard to manage their lives and surround themselves with positive role models and activities. It is quite possible that they agreed to be interviewed because they were working good programs and were successful with continued sobriety. Several stated that they wished to give back to those who are trying to achieve sobriety.

Additionally, five of the six men who were interviewed possessed imposing physical characteristics such as being very tall, muscular, tattooed, and exhibited blunt and brusque behaviors. It surprised the interviewer that internally, they each reported experiencing various levels of anxiety, depression, self-doubt, and fear about who they were and their ability to remain sober and to be successful, externally they presented as

appropriately masculine and had achieved what most would consider material success. It was a good reminder that some individuals try to compensate for perceived deficits by developing hyper-masculine characteristics, and that the fears associated with criticism, rejection, failure, and relapse are universal phenomena for men who have sex with men.

CHAPTER SIX

DISCUSSION

The purpose of this study was to examine the substance abuse treatment experiences of men who have sex with men. In addition, the investigator was interested in discovering the possible implications of divulging or withholding past or present drug related sexual activities on the treatment process and post-treatment outcomes. The therapy records of 24 men were reviewed and analyzed to identify themes and commonalities across sample subjects. Member check or confirmatory interviews were conducted to validate the findings from case reviews.

Two groups of men were identified as the data was analyzed. The first group was composed of men that stated that their substance abuse treatment experience was negatively impacted by their fear that if they disclosed that they had had sex with men, they would be unable to endure the consequences. These consequences included being judged, criticized, ridiculed, assaulted, and being considered gay. Being gay for these men, who identified as heterosexual, was synonymous with being disgusting, sinful, and undesirable to their wives and girlfriends. They recognized that their sexual experiences with men were most often the result of lowered inhibitions and heightened libido due to drug and alcohol ingestion. There was such shame and guilt around this behavior that they could not bear to speak of it with others, and therefore could not resolve the potential implications. Because they could not talk about it, and because these acts had been performed while intoxicated or high, they had very little capacity to discuss it using language that made sense to them. Half of the men who identified as heterosexual chose not to reveal these sexual acts and activities to group members. However, all of the men

in the sample chose to speak candidly to the therapist. These men expressed concerns that they were not able to reap the full benefits of the program. Many were fearful that they would be found out. As they viewed other men who enjoyed relationships with women and were successful in treatment groups, they felt resentful, confused about themselves, and worried that they would not be able to maintain their sobriety. Some men in this group chose not to complete treatment and were discharged from the facility, either voluntarily or involuntarily. Denial seemed to be a key process in allowing these men to repeatedly invent themselves as heterosexual men in relationships with women and in enjoying traditional family life. They became trapped in their own fears and catastrophizing about what would happen if they tried to speak about their sexual experiences. As other men were able to discuss their concerns in group, these men became less and less capable of stepping forward with their experiences and felt left behind in the treatment process.

When some men tried to become more transparent in their group and with roommates, they were discouraged by witnessing staff members or other residents being disparaging to those who revealed this information, and they withdrew back into silence and isolation. Due to their willingness to process their same sex-experiences and discuss possibilities in the safety of the therapy room, half of the men who identified as heterosexual made efforts to be transparent with family members and significant others during treatment. These men reported feelings of empowerment, relief, and hope, because they were able to integrate these elements of their lived experiences honestly with their personal lives while applying the principles of the program.

Nine men in the treatment program identified as gay to the therapist, but only six identified as gay during intake interview at the facility. The men who did not identify as gay in their treatment groups wished to be treated as "one of the guys." Two of these men were partnered with women although they had liaisons with men. The three men who maintained secrecy about their gay identity all went on to complete treatment successfully and to achieve varying levels of post-treatment sobriety.

In addition, some of the men who identified as gay had experienced gay bashing and discrimination from individuals in society and were fearful of exposing themselves to more of this kind of behavior, in a predominantly heteronormative treatment environment. But, when they were able to be transparent with the treatment staff or the therapist, they became more comfortable being open about their identity in the treatment facility. These men began to participate more fully in group work and discuss their sexuality and drug use. Some of these men received positive feedback from heterosexual treatment participants, and others received negative feedback and harassment. The cyclical nature of clients coming into and leaving the facility, allowed men who had become transparent with their sexual orientation to continue to strengthen their identity and their ability to speak openly. This led to opportunities to share in conversations with straight men about victimization and common issues related to substance abuse and other behaviors associated with addiction. Those who were positively reinforced for being forthright and open about themselves, reported that experiencing this gave them a sense of hope that they could be gay and be sober, and that substances were not necessary to live a successful life as a gay man. As these men were able to be openly gay in the facility, group leaders and treatment staff members also became more informed and were

invited to examine their preconceived notions and ideas about what it means to be gay, and to be gay and addicted.

The phenomenon of men having sex with men or sex in groups is associated with the use of methamphetamines and other stimulants (Phillips et al., 2014). It is not uncommon to find that men who have sex with men while under the influence of methamphetamines have also experienced some form of sexual trauma in their early or adult lives (Lopez-Patton et al., 2016). Research in this area also indicates that men who have had experienced sexual trauma in their lives often choose to engage in high risk sexual behavior while under the influence of drugs and alcohol (Hoenigl et al., 2016).

The member check interviews validated several of the themes that emerged during the original case review even though these participants had participated in different treatment programs. All member check interview participants identified as gay and were open with their orientation to varying degrees during treatment, in outpatient programs, and with their families and friends. They all had initial fears about being accepted or valued in heteronormative treatment groups due to past experiences being marginalized as gay men. These men confirmed most of the findings from the case review conducted in Phase I of this study. These included the sometimes surprising experiences they had being accepted in predominantly heteronormative post-treatment groups. Members in such groups had shown these participants gratitude for being open about being gay, because their openness was seen as facilitating deeper group conversations and normalization about the sexual behavior of both gay and heterosexual group members. Like the case review study subjects in Phase I, all member check participants expressed concerns about how effective their treatment episodes would be

according to their ability to be transparent about their sexuality. However, since all of the interviewees were openly gay, they did not experience the same confusion about self, or struggle with the implications of having sex with men while under the influence of drugs, as the heterosexual men did.

All of the men in both Phases I and II who were able to be more open and authentic in their groups, were able to feel empowered, and hopeful. This made it possible for them to complete treatment successfully. Half of the interviewees reported that they currently prefer to attend groups that are composed primarily of heterosexual individuals. They reported that attending these kinds of meetings allows them to focus on their addiction, rather than to revisit coming to terms with their sexual orientation, retelling their coming out stories, or becoming involved in societal disenfranchisement week after week. Men in both groups tended to minimize the effects of sexual trauma and abuse that occurred before they entered treatment. Both gay and straight men displayed a tendency to minimize past promiscuous behavior in lieu of focusing on getting through treatment and addressing the immediate demands of recovery.

The author selected symbolic interaction theory to interpret the findings of this current study because of the unique framework it provides in interpreting the individual and collective experiences of study participants. More specifically, the author was drawn to symbolic interaction theory due to the fluidity and flexibility it offers to individuals and groups in how they make sense of their lived experiences and assign meaning to self, identities, and roles. Because it also illuminates how these meanings constantly vary across contexts according to these individuals' perceptions and interpretation, acceptance

and rejection, the author felt it would be a useful guide in understanding the issues faced in each of these areas by men who have sex with men.

Because symbolic interaction theory is concerned with making sense of how individuals and groups create symbolic worlds, and with how these worlds are then used to shape human thought and behavior (Fisher & Strauss, 1978; LaRossa & Reitzes, 1993), it was an effective tool for providing insight into the processes that take place in the study subjects' lives that help or hinder them in the development of self, various roles and identities, and in the creation of meaning. The findings of the current study confirm that, for many study subjects, failed attempts at developing an acceptable masculine identity, perceived or real rejection from self or others, or the individual or collective assignment of negative meaning to certain identities, roles, interactions, and contexts, lead them to drug use in a desire to cope and, for some, lead to problematic treatment experiences, early discharge, and to relapse (Baker, 2002; Cabaj, 2008; Cheng, 2003; Hardin, 1999).

In addition, because this theory promotes a fluid, processual view of reality that is constantly changing according to symbols and meanings that individuals, groups, and society assign to it, symbolic interaction theory readily lends itself for use in studies that are qualitative in nature and seek to generate new theory to be used in understanding human behavior. The findings of this study clearly indicate that when men who have sex with men are able to be open and honest about their sexual feelings and experiences in the treatment setting, they often began to see themselves in new and positive ways. This unexpected positive outcome can lead to the development of a new concept of self, which can then lead to the formation of new roles and identities that then can become

operational in society. The findings of the current study confirm that participating in these processes can lead to more positive treatment experiences and to more successful post-treatment recovery.

The findings of the current study are consistent with those described in the literature pertaining to men and substance abuse, men who have sex with men, and men who participate in substance abuse treatment programs. However, little is known about the exact motivations for men who have sex with men to either divulge or withhold information related to their sexual activities while in substance abuse treatment settings. This study contributes to the body of literature in this area, by underscoring the importance and role of transparency and acceptance, during and after treatment. It is unfortunate that not all who choose to disclose confusing sexual experiences, sexual activities, and/or sexual orientation meet with positive responses and treatment outcomes.

The findings of the current study also support the literature regarding barriers to seeking and fully participating in substance abuse treatment programs for men who have sex with men. The literature in this area focuses heavily on fear; fears associated with being judged, rejected, ridiculed, or physically harmed by others in the treatment setting are sited as preventing such men from getting the help they need. However, the findings of this study indicate that if men who have men choose to be open about their sexual orientation or sexual activities with others during treatment, their experience can dramatically improve. In addition, the findings of this study demonstrate that MSM who are open and authentic about their experiences during the treatment process, either in individual one-on-one meetings with treatment staff or in the larger group setting, can have a more successful, transformative treatment experience than those that are not. The

findings of the current study also confirm that when men who have sex with men share openly about being who they are, the treatment experience of other men participating in group is also positively influenced, and some negative beliefs, fears, and stigma about MSM are enhanced.

In addition, the findings of this study are in line with those in the literature that highlight the crucial role that family, biological or chosen, plays in successful treatment experiences for men who have sex with men and in the maintenance of long-term sobriety. The findings of this study add to current literature in this area by shedding light on how choosing to be open and honest with significant others about past sexual partners and behavior can lead to more positive treatment outcomes that support healthy partner relationships and long-term sobriety. These findings also indicate, that although being open with a significant other about sensitive information can have negative consequences in the short-term, doing so can provide critical information pertaining to the maintenance of safer sex practices and overall sexual health moving forward.

The findings outlined above clearly demonstrate the contributions that this study makes to the current body of literature on the substance abuse treatment experience of men who have sex with men. It is the hope of the author that the findings of this study can be useful in shedding additional light on factors that contribute to or detract from this population's desire or ability to seek and become involved in treatment, when needed. It is believed that the findings of this study will inform marriage and family therapists, substance abuse counselors, clinicians, and other treatment staff members of what can be effective when working with men who have sex with men so they can offer them the most impactful treatment possible.

Grounded Theory

Because the purpose of this study was to gain insight into the substance abuse treatment experience of men who have sex with men, a grounded theory approach was used to develop the study's original design (Corbin & Strauss, 2008; Holloway & Parahoo, 2006; Strauss & Corbin, 1990). In addition, a grounded theory approach was utilized as this study's data were being gathered, coded, and analyzed (Strauss & Corbin, 1998; Walsh et al., 2015). Therefore, the findings generated by this study readily lend themselves to the creation of a grounded theory lens through which researchers, marriage and family therapists, drug and alcohol counselors, and others working with MSM in substance abuse treatment settings can better understand their individual and collective experiences and put measures in place to both improve and safeguard them. The elements of this grounded theory lens will be discussed here.

The findings of this study indicate that MSM who participate in substance abuse treatment are often struggling with self-acceptance and the development of an identity they feel comfortable with and that they feel is acceptable to those around them. These findings also demonstrate that these men sometimes choose to become involved with drugs and alcohol to mask or cope with feelings of confusion, guilt, shame, resentment, fear, and anger. Sometimes these feelings are the natural result of childhood sexual abuse, family rejection, internalized and/or external homophobia, societal discrimination, or other factors. To continue or support their substance use or to try out roles and identities they deem as appropriately masculine, some of these men become involved in criminal activities which can lead to time in jails, prisons, and institutions. Because of

these kinds of choices and lived experiences, they come to treatment feeling vulnerable, confused, misunderstood, and fearful.

The findings of this study highlight factors that contribute to or detract from the effectiveness or the quality of MSM's substance abuse treatment experiences; these should also be incorporated into the grounded theory lens regarding their experiences and treatment. Some of the findings presented here demonstrate that men who are open about their sexual experiences and preferences with others in treatment are met with respect, acceptance, and varying degrees of understanding and empathy. Contrastingly, other findings seem to confirm some men's fears about being rejected, threatened, bullied, or shunned by others in the treatment setting—clients and staff—when they choose to be transparent about their sexual activities or experiences. In addition, the findings generated by this study illustrate that, for several study participants, using their time in treatment to begin the journey toward self-acceptance and the integration of acceptable identities, can lead to success during treatment and to more successful post-treatment outcomes. These findings also demonstrate that men who are able to be open and honest with significant others and family members about their sexual histories find measures of acceptance and familial support that gives them the confidence they need to move forward into recovery.

Taken together, the findings of this study contribute to the generation of a powerful grounded theory lens that researchers, MFTs, drug and alcohol counselors, and others working with MSM in substance abuse treatment settings can use to make their time in treatment more effective. This lens indicates that experiencing safety and acceptance in the treatment setting and in post-treatment meetings is paramount to their

success. Regardless of how they choose to proceed in treatment with regard to their sexual experiences, if these men feel safe in the treatment setting, they will be more likely to remain in treatment, benefit from the treatment offered, and to move forward into post-treatment recovery. An additional indication of this grounded theory lens is that for many of these men, working with an individual therapist while in treatment provides a safe place and a support for them to begin examining and integrating their experiences into their concepts of self and identity. Then, as they feel prepared, they are able to take advantage of various options provided by the therapist such as exploring the meaning of their sexual experiences, taking them to group, and/or disclosing appropriately regarding their sexual histories or identities to significant others, family members, treatment peers, and friends. Armed with positive treatment experiences, MSM can then move forward into recovery, having utilized their time in treatment to build a firm foundation for post-treatment success.

Implications

There are numerous clinical implications that arise from the current study for marriage and family therapists (MFTs), drug and alcohol counselors, treatment staff members, and others working with men who have sex with men. First, when discussing intimate relationships, sexual histories, and sense of self with these men, they must be knowledgeable and aware of the complexities of human sexual behavior. Clients are often able to perceive how others feel about what they divulge, so it is critical that MFTs, drug and alcohol counselors, treatment staff members, and others working with MSM, are able to discuss sexual behavior openly and without judgment. In relationship to the

current study, those working with MSM in the treatment setting would benefit by reflecting on their own biases regarding sexuality and sexual behavior, because the sexual practices shared by individuals may not be congruent with expected sexual identity in diverse contexts, namely, drug or alcohol enhanced situations.

Second, the study demonstrates that heterosexual men who have sex with men struggle to make sense of their self-identity in the context of their sexual experience. In the treatment setting, MFTs, drug and alcohol counselors, and treatment staff members are in a unique position to help men find language to describe their same-sex activity and explore the meaning and implications of these behaviors that leave them feel confused, angry, and ashamed. Therefore, it is important for those working with this population not to enforce a binary definition of sexuality or ask men to describe themselves in narrow categories. As they experience a sense of safety and build trust with those working will them in treatment, these men will demonstrate a higher level of transparency.

A third implication for therapists, drug and alcohol counselors, and others working with men who have sex with men is that they become informed on current research regarding how drugs and alcohol can contribute to clients' sexual repertoire and how engaging in these kinds of behaviors, while under the influence, can influence how they feel about themselves. A treatment staff member's fear or ignorance of the effects of methamphetamines and other drugs on sexual behavior can be discouraging and damaging to men who are attempting to be transparent about their lived experience. Additionally, having an awareness of how feelings of shame limit many individuals from explaining their experiences and exploring themselves as sexual beings can also help

therapists, drug and alcohol counselors, and treatment staff members be more effective in these cases.

Fourth, subsequent intimate relationships may be adversely affected if treating staff members do not recognize the potential influence of drugs and alcohol on sexual behaviors. Therefore, MFTs, drug and alcohol counselors, and treatment group leaders can support men with any sexual identity by modeling sensitive responses when they choose to share, and by explicitly informing those clients who express discriminatory or critical comments, that such comments are not acceptable, as these sentiments impede recovery. Since this sample was reticent to divulge their sexual identities and behaviors in group, for fear of the group response, treatment group leaders should be trained on how to more effectively moderate these kinds of very sensitive issues while protecting the vulnerability of all group members. In addition, all men in groups need to be educated about the wide variety of sexual behavior to reduce shame and to allow them the opportunity to identify who they are and to contextualize their experience(s) on their own terms, rather than according to how others think they should be, act, or identify.

Fifth, MFTs and others working in treatment settings should exercise caution when collaborating with other treatment team members, clients' family members, and significant others that they do not "out" their client to those who are not prepared to accept or support them. This can be painful and lead to negative treatment outcomes. If MFTs have trouble understanding the sexual issues of their clients who have engaged in drug-induced sexual activities, utmost patience and understanding must be given to the female partners of such men, who will most likely have difficulty with accepting this information. The MFT needs to be prepared to effectively work with family members,

significant others, children, and partners of these men in a way that invites them to also come to terms with their own biases and thinking about the client and his behavior. Creating family sessions that are empowering requires careful preparation and planning.

Lastly, MFTs working in treatment settings, should exercise great care in how they document comments and confessions of men who have sex with men in clinical records. In the treatment facility where this study was conducted, all treatment staff members had access to the researcher's therapy notes. It is not necessary for treatment staff members to have access to type of sensitive information, as they may not guard this information, or misuse it in conversations with others in the treatment setting. The education of drug and alcohol counselors is insufficient and does not currently prepare them to competently interact with men with variable sexual identities. Much of their education is focused on administrative duties and group-leading techniques. In addition, if therapy notes are subpoenaed, it is best to only include a treatment summary that documents critical portions of therapy sessions that the client would not object to being shared in an open court of law.

The findings of the current study clearly indicate that men who have sex with men and those who work with them in substance abuse treatment settings could benefit from additional research in this area. Treatment models and outcomes are needed for programs specifically designed for men who have sex with men. Studies that effectively address the issues facing this clinical population could alleviate the negative associations and stigma that are often associated with identifying as anything other than heterosexual, substance abuse in general, and same-sex behavior.

In the current study, the sample subjects' treatment experience took place in a heteronormative facility. One area of future research would be to learn how having an open and affirming treatment staff, using a gay-normative treatment approach, would impact treatment experiences and post-treatment outcomes for both heterosexual and gay men. Comparisons of this format with men in heteronormative groups, led by a mix of therapists, could shed light on therapist behaviors, beliefs, and worldviews that contribute to men's sobriety. The findings of such a study could have far-reaching effects. Study findings outlining positive treatment outcomes of men who had received an open and affirming context for recovery, would provide positive role models of MSM who are managing life well. Findings of such a study would be a stark contrast to how men who have sex with men are currently described in research, as often turning to drugs and alcohol to cope with daily life, because they do not identify with heteronormative male role models.

In addition, the findings of the current study highlight the need for treatment staff to be more effectively trained to meet the needs of men who have sex with men. Therefore, it would be helpful to conduct qualitative studies of treatment staff and frontline group leaders in treatment centers to understand how they find or derive meaning in the sexual behaviors of men in treatment. Understanding their attitudes, factors contributing to their acceptance or rejection, and responses to admissions of clients' same-sex activity could then be used in educational formats. More information is needed about the treatment outcomes of men who openly discuss their sexual behaviors in treatment groups versus those who choose not to acknowledge or discuss their

sexuality or behaviors in that context. As drug abuse statistics increase, the clinical, educational, and research implications are many.

Strengths and Limitations

The strengths of the present study are many. As there is a need for research on the substance abuse treatment experience of men who have sex with men to more adequately address their unique treatment needs, the findings of this study provide important insight into factors that contribute to positive treatment experiences and post-treatment outcomes. In addition, this study's findings provide those working with MSM in treatment settings with clear case examples of what was and was not effective in working with this population across subgroups of men who have sex with men. Several strengths make the current study unique. First, it is one of few studies of its kind that examined the treatment experiences of men who have sex with men using therapy and process notes and a follow-up face-to-face interview. Second, the member check interviews conducted during the current study with men who had been through other treatment programs validated most of the findings of the case review, demonstrating validity, credibility, and transferability. While these interviews confirmed most case review findings, they also provide important new insight into how men who have sex with men achieve and maintain long-term sobriety both during and after treatment. Third, the researcher who conducted the current study and participated with the men in Phase I, and Phase II, is a member of the LGBT community. Although he did not disclose this information to study participants, he was considered a safe individual with whom they could share their experiences openly, without fear of being judged.

The current study had the following limitations. First, it was conducted using a sample comprised of only men. Although the researcher did have access to female subjects while working with these male study subjects, they did not present with the same inclusion criteria in individual therapy. Because of this, he selected to focus the current study on only male subjects. Second, although the original study design for the current study included conducting member check interviews with sample subjects after they had completed treatment to validate case review findings, the interviews were conducted with participants who had participated in substance abuse treatment programs elsewhere. It could have been helpful to interview a sample of men who had been through the treatment center where the case review was conducted. However, because it was not possible to locate or gain access to them while Phase II of the study was taking place, interview participants were identified through snowball sampling and were interviewed using approved study materials. Although the present study had these limitations, it is the firm belief of the author that its findings make a substantial contribution to the current body research concerning what makes substance abuse treatment experiences effective substance for men who have sex with men.

Conclusion

This study makes several unique and much needed contributions to the current body of research on the substance abuse treatment experience of men who have sex with men. The researcher strongly believes that the findings of the current study can provide marriage and family therapists, drug and alcohol counselors, treatment staff members, and others working with men who have sex with men with useful information and insight

into the factors that frame their individual and collective treatment experiences. The findings of the current study also shed light on several previously unknown factors that influence MSM in their desire to seek, participate in, and/or to complete treatment for their substance abuse issues. In addition, the findings of the present study also identify several factors that can enhance the treatment and post-treatment recovery experiences of men who have sex with men. It is believed that these findings, taken together, can be useful to those working with this population because they effectively highlight a connection between factors that positively and negatively influence the treatment experiences of these men and their ability to remain sober after treatment. It is the hope of the author that the results, findings, and insight generated by this study will be used to improve and enhance existing treatment programs for MSM and inform others want to create more effective treatment programs, some that are specifically equipped to address the needs this clinical population so they may enjoy lives free of substance abuse and addiction.

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APPENDIX A

TELEPHONE RECRUITMENT SCRIPT

Script Key:

Scott S. Johnson, Student Researcher = SJ

Study Participant = SP

……..

SJ: "Hello, May I please speak to (Study Participant's Name)?"

SJ: "Hello, is this (Study Participant)?"

SP: "Yes, this is he…"

SJ: "This is Scott calling from [treatment center]. How are you?"

SP: "Fine thank you…"

SJ: "I am glad to hear that you are doing so well. As you may remember, in addition to working at [treatment center] and at [treatment center] as a marriage and family therapist trainee, I am also a doctoral student at Loma Linda University studying marriage and family therapy.

SP: "Oh Yes, I remember that now that you mention it."

SJ: "As a part of completing my doctoral program, I am currently conducting a research study examining the quality of the men's substance abuse treatment program currently offered here at [treatment center], [treatment center], and [treatment center]."

SP: "Really? That sounds good. Tell me more."

SJ: "To better understand the factors that contributed to or detracted from your treatment experience, I would like to invite you to participate in this study. Your participation would involve an interview lasting approximately 20-30 minutes. The interview would

be in the form of a guided conversation about your substance abuse treatment experience here at [treatment center]. All of the interviews will be audio taped and transcribed. During this process, any information identifying you will be replaced by a number or pseudonym to protect your privacy."

SP: "Okay. That sounds interesting. Is this a required part of my program?"

SJ: "No, it is not. Your participation in this study is completely voluntary and you would be free to leave the study at any time, with or without cause.

SP: "Alright."

SJ: "Should you choose to participate, I would happily meet with you here at [treatment center] in the administration building, or if you prefer, I can meet with you at another location of your choice. At the time of your interview, you will receive additional information about the study and you will be asked to sign an informed consent form. In addition, you will receive a $25 Stater Bros gift card as my thanks for your participation and time. Would you like to participate?"

If Yes:

SP: "Yes, I think I would like to be part of the study."

SJ: "Great! Thank you so much. I appreciate your willingness to participate and value your input. Can we set a time for your interview now?

The student researcher, Scott Johnson, would then set an interview with the study participant, including interview date, time, and place.

SJ: "If you need to contact me before our scheduled interview for any reason, you may do so at [phone number] or at [university email address]. I very much appreciate your participation and input and I look forward to meeting with you.

If No:

SP: "No thanks, I would rather not participate in the study."

SJ: "I understand. It has been very nice speaking to you today. If you change your mind about participating, you can contact me here at [treatment center] at [treatment center phone number] or at [university email address]. Goodbye."

SP: "Goodbye."

APPENDIX B

RECRUITMENT LETTER

Date of Letter, 2016

Client Name

Client's Street Address

Client City, State, and Zip Code

Dear Client Name,

Hello, I hope that this letter finds you safe and well. As you may remember, in addition to working at [treatment center] and at [treatment center] as a marriage and family therapist intern, I am also a doctoral student at Loma Linda University studying marriage and family therapy. As a part of completing my doctoral program, I am currently conducting a research study examining the quality of the men's substance abuse treatment program currently offered here at [treatment center], [treatment center], and [treatment center].

To better understand the factors that contributed to or detracted from your treatment experience, I would like to invite you to participate in this study. Your participation would involve an interview lasting approximately 20-30 minutes. The interview would be in the form of a guided conversation about your substance abuse treatment experience

(Continued on page 2)

here at [treatment center]. All of the interviews will be audio taped and transcribed. During this process, any information identifying you will be replaced by a number or pseudonym to protect your privacy.

Your participation in this study is completely voluntary and you would be free to leave the study at any time, with or without cause. Should you choose to participate, I would happily meet with you here at [treatment center] in the administration building, or if you prefer, I can meet with you at a location of your choice. At the time of your interview, you will receive additional information about this study and you will be asked to sign an informed consent form. In addition, you will receive a $25 Stater Bros gift card as my thanks for your participation and time.

If you would like to participate in this study or have any additional questions regarding this study, please contact me before Date , 2016 at [phone number] or at [university email address]. I would very much appreciate your participation and input.

Sincerely,

_____

Scott S. Johnson, M.S.

APPENDIX C

INFORMED CONSENT

LOMA LINDA UNIVERSITY INFORMED CONSENT

Purpose and Procedures

You are invited to participate in a dissertation research study about the substance abuse treatment experience of men at [treatment center]. We are especially interested in understanding the experience of those who face challenges that can be difficult to share with others in a group setting, such as having had sexual experience with other men. We are interested in learning how to improve the treatment experience of future clients so that they will have greater success in recovery. This study is being conducted by Scott Johnson, who is a doctoral student, under the supervision of a faculty mentor, Dr. Winetta Oloo. The study involves a case review of men who worked with Scott in individual therapy during treatment.

Your participation will involve an interview lasting approximately 20-30 minutes. The interview will take the form of a guided conversation about your substance abuse treatment experience at [treatment center]—what you feel about the program and how your specific treatment needs were met. The purpose of the interview is to learn from your experience. The interviews will be audio recorded and transcribed.

Risks

The risks to you are the possibility that some issues may be raised during the interview that make you uncomfortable or that you may not want to discuss. If you were to feel uncomfortable talking about a particular topic, you are free to stop talking about that topic and/or withdraw from the study with no ill will or penalty.

Benefits

Though participation in this study may be of no direct personal benefit to you, the potential benefit to those working in substance abuse treatment programs is great. What we learn from you will help counselors, staff, therapists, and others to be more sensitive to the issues that may impact treatment experience and be better able to help men succeed in recovery.

Participant Rights

Your participation in this study is completely voluntary. You are free to choose what information you reveal. You may decline to answer a question, stop the audio recording, or to terminate the interview at any time. Choosing not to participate will not affect your ability to receive present or future services at [treatment center] or with Scott Johnson.

Initial _____

Date _____

Confidentiality

All personal information revealed in the interview will be kept strictly confidential. Your name will be deleted from the interview transcription and from the audio recorder used to record the interview. After transcription, all of the interview tapes will be destroyed and transcriptions will be retained de-identified. In the analysis of the interviews, you will be identified by a number or a pseudonym. All identifying material will be modified when quotes of case examples are used in the presentation or publication of study results.

Costs

There is no cost to you for participating in the study.

Reimbursement

You will receive a $25 Stater Bros gift card for your participation in this study.

Impartial Third Party Contact

If you wish to contact an impartial third party not associated with this study regarding any question or complaint you may have about the study, you may contact the Office of Patient Relations, Loma Linda Medical Center, Loma Linda, CA 92350. You may also contact them by phone at (909) 558-4647 or via email at patientrelations@llu.edu for information and/or assistance.

……

Informed Consent Statement

I have read the contents of this form and have listened to the verbal explanation given by the investigator. My questions have been answered to my satisfaction. I hereby give voluntary consent to participate in this study. Signing this consent does not waive my rights, nor does it release the investigator, institution, or sponsors from their responsibilities. I may contact Scott S. Johnson, M.S., at [university email address] or at [phone number], or faculty Mentor, Winetta Oloo, PhD, at [university email address] or at [department phone number] ext. [extension], if I have additional questions or concerns.

I have been given a copy of this consent form

_____ _____

Signature of Subject Date

I have reviewed the contents of the consent form with the person signing above. I have explained potential risks and benefits of the study.

_____ _____

Signature of Investigator Date

APPENDIX D

MEMBER CHECK INTERVIEW GUIDE AND QUESTIONS

Each member check interview will address all of the following general questions, followed by probes to expand and clarify meaning and to pursue topics raised by the respondent. The order and wording of the questions may be altered to fit the flow of the conversation. All of the member check interviews will be conducted by the student researcher, Scott Johnson.

Getting Started

1. Each interview will begin with a few moments of "small talk" to engage the respondent and help them feel comfortable. Because all of the respondents are former clients of the student researcher, Scott Johnson, it should not be difficult to reconnect with them.
2. The student researcher, Scott Johnson, will then review the purpose of the study and carefully review the informed consent document with the respondent, stressing confidentiality and eliciting their questions. In addition, Scott Johnson will obtain the informed consent of each participant.
3. The student researcher, Scott Johnson, will then remind the respondent that they are participating in a guided conversation; that we are interested in learning about their substance abuse treatment experience at [treatment center]; we are not evaluating them, but learning from them. Scott Johnson will also remind each participant that they may decline to answer any question or shut off the tape or conclude the interview at any time without penalty.

Interview Questions

Part I: Background

1. What was going on in your life when you chose/were mandated to seek help/treatment for your substance abuse issues?
    - Why did you select [treatment center]?
    - Did you come because you wanted to or because of a family member or friend?
2. When you arrived at the treatment facility, what kinds of things made you feel comfortable and welcome/uncomfortable and unwelcome?
    - Were you received warmly? By whom?
    - Did clients/treatment staff members take time to welcome you?
    - Did you encounter people you felt you could connect with/trust?
3. What factors contributed to your desire to stay in treatment and to complete your program/leave treatment and not to complete your program?
    - Did you feel like your personal treatment needs were being met? Why/why not?
    - Did you feel like you were heard and understood by treatment counselors and staff? Why/why not?
    - What factored into your decision to complete/not complete your treatment program?

Part II: Extension of Case Review

In my review of your case, I noted that we discussed _____. My observations indicate that _____ and _____ contributed/detracted from clients' overall experience in treatment. I would like to ask you the following questions to see if these observations are valid.

4. What kinds of things made you feel like you could/could not openly share about your personal struggles/experiences while attending group?
    - Were you concerned about what staff members/other clients might think/say/do if you shared some of your personal experiences with them?
    - If you did feel comfortable sharing, was it because of who was leading the group or because of other clients present?
    - What kinds of things could have been done in the group setting to make you feel better about sharing more?
5. Describe your relationships with other clients/roommates during treatment?
    - Did you form lasting friendships with other clients during your treatment experience?
    - If so, how were they being around you to make forming relationships possible?
    - If not, how were other clients being around you that made you not want to get close to them?
    - Did you have difficulty with other clients during treatment? Please explain.

6. What factors led you to seek individual therapy while in treatment?
    - Were you referred to therapy by your primary counselor, or did you ask to work with a therapist?
    - What did you expect to gain from working with a therapist during treatment?
7. How did participating in individual therapy while in treatment affect your treatment experience?
    - What did I do or say during our individual therapy sessions that made you feel comfortable about sharing with me about your personal life and challenges?
    - What could I have done differently to increase your level of comfort?
    - Do you feel like our work together in therapy had an impact on your treatment experience? Why/why not?
    - How did receiving individual therapy during your treatment experience help you in your recovery?
8. In your opinion, what would have made your treatment experience at [treatment center] more beneficial to you?
    - In what ways did treatment staff members met your specific treatment needs?
    - What could treatment staff members and other clients have done to improve your overall treatment experience?

9. In what way(s) has your treatment experience at [treatment center] affected your recovery?
    - How do you feel about the instruction you received while in treatment at [treatment center]?
    - Do you feel like you received the information/tools you need to remain abstinent while in treatment at [treatment center]? Why/why not?